

Integrated Behavioral Health Program Case Studies

Final Report

March 2010

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I. Introduction

The California Endowment funded the Integrated Behavioral Health Project (IBHP), a four-year program implemented in 2006, to advance the field of integrated behavioral health, improve access to behavioral health services, reduce stigma, and improve treatment outcomes for underserved populations. To advance the field, IBHP implemented several core strategies: 1) grant making to identify, enhance, and improve promising clinic practices; 2) building and supporting a Learning Community of providers and stakeholders in the fields of primary care and behavioral health; and 3) advancing a policy and advocacy agenda to affect systems changes “in the trenches” and at the state level.

The following report presents case studies of five clinics and one clinic consortia that were funded through IBHP’s grant making strategy. These clinics offer a “proof of concept,” showing that it is possible for community clinics to integrate behavioral health and serve the diverse behavioral health needs of the safety net population. Prior to their involvement in IBHP, all of these clinics were motivated to begin integrating primary care and behavioral health services in response to unmet needs in the communities served. In fact, many of these efforts were initiated by clinic leadership (CEOs and CFOs) who learned about integrated care through national forums and experts offering evidence of improved care quality and cost savings. Several of these clinics began by implementing specific integration models (e.g., the Strosahl model), which overtime, were adapted and adjusted to fit the local context and capacity of the community and clinic environment.

II. Case Study Approach

Two questions guided the development of these case studies:

1. What does it take for primary care clinics to integrate and provide behavioral health services?
2. What is the role of community clinics in addressing the behavioral health needs of the safety net population in communities?

Information presented in this report was drawn from multiple sources: a review of documentation and materials provided by the grantees; interviews with or site visits to the clinics from November 2009 through January 2010; and interviews with grantees at annual IBHP convenings. The case study compilation documents the implementation experiences of the IBHP grantee across several program elements including population served, services offered, coordination across providers, implementation challenges, and the clinic’s perspective regarding the core components of integrated behavioral health. In addition, the case studies document unique program elements and promising practices by site. The report also summarizes findings across the sites regarding how to “make the case” for integration and lessons learned across the six vanguard sites. Geographic location, clinic size, existing resources and levels of administrative buy-in are just a few contextual variables that create significant variation across the six sites. The “proof of concept” these clinics provide is important field-based evidence of how

community clinics can play a vital role in enhancing access to and the delivery of behavioral health services for the safety-net population across California.

Each case study is organized into the following sections:

a) Clinic History and Description

b) Motivation for Integration

c) Approach to Integrated Behavioral Healthcare

- Patient Volume and Diagnoses, Referral and Reimbursement Sources
- Behavioral Health Services Provided
- Screening Procedures
- Warm Hand-off between Primary Care and Behavioral Health Providers
- Case Management
- Information Sharing (medical records, cross-provider case consultation)
- Communication & Coordination
- Challenges implementing IBH services (Clinical, Administrative, and Financial)
- Core Components of Integration

d) Innovative Project Goals and Accomplishments

Appendix A presents a comparative assessment across the six vanguard sites of the various approaches to integrated behavioral health.

III. Mental Health and Substance Abuse Diagnoses Treated in the Clinic Settings

A common question regarding integrated behavioral health concerns the type of behavioral health issues that can be treated in the primary care setting. The assumption is that primary care clinics with integrated behavioral health services do not treat the more complex mental health cases, but instead focus on providing health education, behavioral interventions that impact physical health conditions, or treatments for mild or situational mental health issues. In reality, the nature of services and populations served in primary care settings does not parse out this way. Based on evidence from the community clinics participating in IBHP, clinics serve a diversity of patients with a range of behavioral health needs that vary in complexity and severity.

Four of the clinics featured in these case studies provided data on the diagnosis of patients treated through their behavioral health programs. As Table 1 shows, all four clinics treat patients with serious and more moderate mental health needs, as well as substance abuse issues. Well over half of the patients treated have a diagnosis of serious mental illness, including: schizophrenia; schizoaffective,

bipolar, panic, obsessive compulsive, and psychotic disorders; major depression; anxiety; PTSD; eating disorders; autism; and serious emotional disturbance.

Table 1: Primary Diagnoses of Serious Mental Illness and Substance Abuse Disorders Served in Clinics

Clinic/Clinic System	Serious Mental Illness	Substance Abuse*	Other Mental Health Issues
Golden Valley**	66%	2%	38%
Mendocino	58%	11%	31%
Open Door	60%	14%	26%
Sierra Family	75%	4%	21%

*Across the clinics, many patients have co-occurring substance abuse disorders. This table presents data only on primary diagnosis, so it is likely that substance abuse is underreported.

**Percent of total behavioral health service encounters

Among the patients treated for substance abuse issues, diagnoses included abuse or dependence on alcohol, opioids, amphetamines, cannabis, and tobacco. Other mental health diagnoses ranged from stress reduction and anger management to Dysthymia and bereavement, sleep disorders, and Attention Deficit Disorders.

IV. Case Studies of the IBHP Vanguard Programs

1. Family Health Centers of San Diego (FHCSO)

a) Clinic History and Description

Family Health Centers of San Diego operates twenty-nine locations throughout the County of San Diego, including 12 primary care clinics, 3 dental clinics, an HIV clinic, and 3 mobile medical units that provide healthcare services at approximately 61 community sites. In 2008, Family Health Centers of San Diego cared for over 120,000 individuals through over 490,000 patient encounters. In 2008, 80% of FHCSO patients were uninsured and 97% had incomes at or below 200% of the Federal Poverty Level. FHCSO is accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO), an entity responsible for establishing quality standards for health care organizations throughout the nation.

Seven of FHCSO's clinic sites offer behavioral health services, five of which through an integrated behavioral health model. The most recent clinic to implement integrated behavioral health services is the Grossmont Spring Valley Family Health Center (GSVFHC). Grossmont is located in Spring Valley, in the eastern part of San Diego County. Data on East County San Diego from the 2005 California Health Interview Survey (CHIS) illuminates the unmet need in this region for accessible mental health services. East County adults reported a higher quotient of 'psychological distress' than the Central region, (30% compared to 19%). Only four percent of survey respondents reported they had, 'received psychological/emotional counseling in [the] past year.' Moreover, the suicide rate in East County is the highest of all San Diego County regions at 11 per 100,000. Both an indicator and consequence of the unmet need in East County for mental health and substance abuse services, this region exhibits the highest rate in the County of adolescents who report having, 'ever tried marijuana, cocaine, sniffing glue, [or] other drugs.' A third (33%) reported having tried drugs, followed by the Central region with only 16 percent.

In 2007, this clinic (GSVFHC) treated over 11,000 unduplicated patients, 65 percent of whom identified as Hispanic and 78 percent indicating that their income was under 100% of the Federal Poverty Level (FPL) guidelines. A quarter (25%) were uninsured and half (50%) had Medi-Cal and/or Medicare.

b) Motivation for Integration

FHCSO has a long history of providing behavioral health services, dating back to the 1980s when they received a grant to provide substance abuse treatment to new mothers dealing with addiction. FHCSO began operating a freestanding mental health clinic in the 1990s and since 1998, all new clinics that have opened have dedicated space for behavioral health services. In 2003, they joined the Health Disparities Collaborative and decided to co-locate behavioral health services in primary care, which was consistent with the need to provide wrap around services to better respond to the needs of their

population. The vision for integrating primary care and behavioral health came from the CEO looking for opportunities to build and expand behavioral health services into clinic operations.

In addition to clinic leadership support, another factor motivating FHCS D to integrate behavioral health stemmed from a desire to be responsive to the needs of patients and the community, more generally. The Community Advisory Group specifically requested these services based on a lack of options available throughout the county. Specific services they requested included information and resources on domestic violence and the impact on the family, prevention and treatment of incest, and substance abuse treatment services in a “one stop shop.” In the beginning, patients were more interested in the convenience of co-location rather than the coordinated, collaborative approach across providers.

c) Approach to Integrated Behavioral Healthcare

Family Health Centers of San Diego IBH Model Features

Title of BH Staff	Peer Consultant
Patients Seen/Day	6-10 billable patients/day, plus uninsured patients and warm hand offs
Population Served	80-85% meet SMI criteria (major depression, anxiety, PTSD)
Productivity Incentives	\$5 incentive cards for seeing 8+ patients daily
MH/SA Services Provided	Mental health assessments; crisis intervention; individual, group, and family therapy; adult and child psychiatry; clinic, home and school-based services; certified Domestic Violence Prevention program; linkage to community resources; referrals to substance abuse treatment; provide psychoeducational materials; assist with self-care management; and co-facilitate pain management groups with PCPs

Behavioral Health Service Volume, Patient Diagnoses, Referral Sources, and Reimbursement Sources.

In 2006, FHCS D provided behavioral health services to 4,570 patients with 29,705 encounters. Over 80% of these patients met SMI criteria and the most common psychiatric diagnoses include Major Depression, Generalized Anxiety Disorder, and Post-Traumatic Stress Disorder (PTSD). The average behavioral health services visit is 20 to 30 minutes and approximately 25% are self-referred. The average number of visits (depending on the site) ranges from 4 to 10. Limitations on the number of visits depend on the program; typically there is a limit of 10 BH visits a year with unlimited doctor visits. The programs are funded by Medi-Cal (state and federal) and county (MHSA).

Behavioral Health Services Provided. Behavioral health services at FHCS D include mental health assessments, crisis intervention, individual, group, and family therapy, adult and child psychiatry, psychiatric medication and linkage to community resources. Behavioral health providers assist with self-care management, co-facilitate pain management groups with Primary Care Physicians, and make referrals to community-based organizations for substance abuse treatment.

FHCS D offers both short- and long-term therapy services. Short-term therapy is 8 weeks and typically results from a PCP referral for self-care management, assistance with appointment and medication compliance, and for patients with co-occurring diabetes and depression. Longer term therapy is similar to a traditional mental health program where the patient is seen for up to 6 months depending on the complexity of the mental health condition.

Family Health Centers wants to expand their health promotion services to provide more focused group and individual services for smoking cessation, weight loss and nutrition, diabetes management, pain management, domestic violence, and post-partum depression. FHCS D currently offers one pain management group that averages approximately 6 patients. To maximize billing for group therapy, the medical provider sees each patient individually for a 15 minute medication appointment, which allows them to bill for all 6 patients seen.

Screening Procedures. As part of the registration packet, FHCS D screens all new patients coming in for primary care services using the PHQ-9. Behavioral health providers follow up with patients that have elevated scores on the PHQ-9. Any patient indicating potential danger to self or others is seen immediately by a behavioral health provider. Behavioral health providers use the CAGE to screen for substance abuse, as needed, or if requested by the PCP. They also track appointment compliance (no show rates) as part of their care management effort.

Women receiving pre-natal care services at FHCS D are routinely screened at various points during pregnancy using the Edinburgh Depression Scale; women identified with, or at high risk, of depression are able to access behavioral health services and care coordination. Prior to BH program expansion in 2008, these women were encouraged to access mental health services at a separate clinic site that where they received medical services which resulted in poor follow through.

“Warm Hand-Off” between Primary Care and Behavioral Health. The Warm Handoff between the medical provider and the behavioral health provider occurs in the exam room, and an appointment is scheduled for follow-up. The PCP introduces the behavioral health provider as a “peer consultant” during the warm hand off, and then the behavioral health provider takes that patient to a separate office to free up space in the medical exam room.

Case Management. Behavioral health staff provide case management services, connecting patients to needed community resources. The behavioral health staff share a resource binder that has been developed collaboratively over time. FHCS D is reluctant to hire behavioral health staff that are not willing to do some level of case management in addition to providing therapy. They rely on partnerships with community based organizations to help patients access service referrals for legal advice, domestic violence shelters, substance abuse treatment, housing, and food.

Information sharing through medical records. Family Health Centers is starting the process of implementing electronic medical records, but currently still uses paper charts. Until EMR is fully implemented, tracking behavioral health data and outcomes is extremely difficult and the data are not easily accessible. PCPs review PHQ-9 scores and case notes that are in the mental health tab of the chart.

Communication & Coordination across providers. FHCS D recognizes the importance of increasing the behavioral health provider presence in clinics, with the behavioral health staff interacting as frequently as possible with the medical staff. They have weekly meetings between medical and behavioral health providers to increase communication and coordination. When a PCP requests a consultation with the psychiatrist, a behavioral health clinician is often included in the meeting to enhance coordination. The

behavioral health providers present monthly mental health educational workshops to all of the medical staff. To increase visibility of the entire team, behavioral health providers share presentation responsibilities and rotate each month. Topics are developed based on the needs expressed by the primary care provider and have included: dealing with difficult patients, and information on autism, PTSD, and Asperger's Syndrome.

Another strategy FHCS D uses to enhance communication and elevate awareness of mental health issues is a one page weekly newsletter disseminated to the 700 employees across the clinic system called the "Weekly Huddle." This newsletter is used as a vehicle to share patient case studies that illustrate the impact of behavioral health services on patient health outcomes.

Challenges implementing integrated behavioral health services in the community clinic setting. FHCS D identified several clinical, operational and financial challenges associated with implementing behavioral health services in the community clinic setting.

1. Clinical integration challenges:

Service Capacity Gaps. FHCS D experiences challenges accessing certain behavioral health services including substance abuse detoxification placements, psychiatry services, and psychotropic medications for uninsured patients, and psychiatric hospitalization. PCPs are comfortable working with stable, high functioning patients with schizophrenia because they can access psychiatric consultation two times a month for psychotropic medication consultation. However, there are some controlled substances and anti-psychotic medications that generate an automatic referral to the psychiatrist which creates access issues for some patients. The organization requires additional assistance with injectible or intramuscular medications. Child psychiatry services are limited to 8 hours a week at FHCS D which is insufficient given patient demand.

Workforce Issues. Hiring the right providers to work in a primary care setting and limiting staff turnover are ongoing challenges faced by FHCS D. From their perspective, the necessary characteristics for effective BH providers working in a clinic setting include: flexibility, commitment to a model of short term therapy, comfortable building rapport with and marketing skills to medical staff, tolerance for multiple interruptions, and a shared philosophy for a team approach to care. BH providers have to break out of the model of "people make my appoints and patients come to me." An added challenge is competing with the hospitals for bilingual, bicultural providers when the hospitals can offer higher salaries.

2. Administrative and Operational Challenges

Medical Provider Resistance. During the course of implementation, FHCS D worked through the issue of negotiating appropriate space for behavioral health services, as well as medical providers learning how and when to make appropriate referral to behavioral health providers. The key to overcoming the resistance was to demonstrate to medical providers how an integrated model can be advantageous to them by alleviating burden and supporting their

productivity goals. Reducing no shows and helping patients increase medication compliance were additional BH outcomes that were important for increasing buy-in from medical providers. Physical space is an ongoing challenge. Even with medical provider buy-in, there was limited space in the clinic for BH service delivery. It is not appropriate to conduct behavioral health services in a medical exam room, so this needed to be resolved with the clinic administration.

Accessing Medical Records/Chart Information. FHCS experienced early challenges and resistance from PCPs to obtain the patient consent that would allow BH providers access to medical information in the chart. The clinic addressed this through JCAHO accreditation, which requires only one chart if primary care and mental health services are co-located. Mental health has a separate tab in the medical chart, but all providers can access all information.

Challenges to standardization. Clinic administration needs to finalize the training manual for new medical providers and the Human Resource department needs to incorporate an integrated care philosophy into job descriptions and performance reviews. Better documentation and formal operations procedures help keep practices consistent. Establishing a formal Quality Assurance and Improvement plan would also help standardize operations within the clinic.

3. Financial Challenges

Same Day Billing: Related to the ubiquitous concern regarding the inability to bill for a medical and behavioral health visit on the same day is the loss of revenue associated with providing crisis intervention services during a primary care visit. Behavioral health providers are often called in when patients are in crisis situations. However, these complicated and often time consuming interventions cannot be reimbursed if the patient's primary care visit is billed.

Core Components of Integration. FHCS identified the following core components of integration:

- Co-location
- Collaborative team approach
- Buy-in from medical providers and clinic leadership
- Routine communication and coordination across provider
- Information sharing through medical records and case conferencing
- Case management and the warm handoff are core components that are very important, despite the fact that providers do not get reimbursed for these activities

d) Innovative Project Goals and Accomplishments

For the IBHP Phase II Innovative Project, Family Health Centers of San Diego focused on increasing access to needed mental health and substance abuse treatment services through increased screening and identification. The following section highlights the goals and accomplishments of their Innovative Project implemented between October 2008 and September 2009.

Goal 1: Screen a minimum of 400 adult primary care patients for Depression or Substance Abuse.

- Exceeded target and screened 437 patients in the primary care setting
- Identified and treated or referred 69 adults for substance abuse issues
- Providers were trained in psychopharmacology and updated on behavioral health issues at monthly meetings

Goal 2: Treat a minimum of 75 patients for depression

- Exceeded target and screened 112 patients for depression
- PHQ-9 was administered during most visits, except when there were time constraints or staff shortages
- Practice management system was used to log and report numbers of patients and number of visits
- Medical providers reported satisfaction of the referral process to behavioral health staff, the clinic director, and the project manager

Goal 3: Treat or refer a minimum of 50 patients for substance abuse treatment

- Patients requiring detox were referred to other providers
- Practice management system was used to log and report numbers of patients and number of visits
- Intended to track patient attendance at groups, but this was deemed too time intensive to do consistently

Goal 4: Self-management goals will be documented for a minimum of 90 patients

- 188 patients had self-management goals documented in their charts
- Compliance for self-management goals was tracked in a spreadsheet, with the goal of incorporating this into the electronic health records system once it is implemented.

Goal 5: Assess the mental health needs of 25 children referred by the on-site pediatrician

- Assessed 58 children, 90% of whom received behavioral health treatment or were referred for treatment as a result of the assessment
- Documented issues identified in charts and communicated with pediatrician, as needed

Other Accomplishments:

- According to the clinic director, patient and staff complaints have decreased as a result of the co-located behavioral health program
- Communication between behavioral health and primary care staff has improved with more routine case consultation.
- Participation in Phase I and II of IBHP put them in a good position with the county to help patients access needed mental health services during the economic crisis and mental health budget cuts.

- Successful participation in IBHP has improved the visibility and awareness of the program.

2. Golden Valley Health Centers (GVHC)

a) Clinic History and Description

Golden Valley Health Centers (GVHC) is a 38-year-old multi-site Health Center serving the Central Valley of California with an operating budget of approximately \$35 million. GVHC has developed a system of 25 medical sites and eight dental sites, including two free-standing Women's health centers, three school-based centers, 3 mobile clinics and a homeless health care clinic. A total of 68,641 patients were served in 2007. Patients are 80% Latino, primarily farm workers and their families. Sixty percent of patients have Medi-Cal, and almost 40% are uninsured, or underinsured. GVHC provides comprehensive primary care, dental and behavioral health services to an ethnically diverse population, including migrant and seasonal farm workers, Southeast Asian refugees, and the homeless population of Modesto. Forty percent of patients are monolingual, speaking a language other than English.

GVHC has several core values:

Advocacy: Working for social change to promote equality in health care.

Access: Dedication to increasing access to health care for the underserved.

Efficiency: Provision of services in a prompt, courteous and cost effective manner.

Respect: Respecting the inherent value of each and every person with whom we interact.

Innovation: Commitment to the creative and intelligent use of new technology and clinical practices.

Excellence: Provide the best possible health care to our patients.

Vision: Golden Valley Health Centers will be known as a premier organization ensuring access to high quality, culturally responsive and comprehensive primary health care for all, especially the underserved.

b) Motivation for Integration

The leadership of Golden Valley Health Centers (CEO, CMO) introduced behavioral health services after hearing a presentation from Kirk Strosahl. Golden Valley's CEO, Michael O'Sullivan, a former Peace Corps member, adopts a public health philosophy and remains committed to providing vital services to the most vulnerable members of the community. GVHC has adapted the Strosahl model of integrated care to be more responsive to the needs of the patients.

Golden Valley Health Centers began integrating behavioral health into its primary care services five years ago in response to overwhelming national research evidence showing that many primary care patients suffer behavioral health concerns, which adversely affect their health. In addition, most primary care patients prefer to receive counseling or mental health medications where they receive physical health care. At Golden Valley, Behavioral Health is not a program, but rather a part of the array of services offered to the community, which makes these services less vulnerable to budget cuts. Behavioral health services at GVHC are intended to promote overall wellness and motivate patients to take a proactive and preventative approach to their health.

c) Approach to Integrated Behavioral HealthCare

Golden Valley IBH Model Features

Title of BH Staff	Behavioral Health Clinician (BHC)
Patients Seen/Day	Schedule 14 to 15 in 30 minute slots; average of 40% no shows, with 2-4 warm hand-offs/day
Population Served	MH/SU complexity of the patients varies by clinic site. Across the clinic system, 66% SMI, 38% other BH issues, 2% Primary SA disorder.
Productivity Incentives	Productivity incentives are based on a monthly average and are reached with 10 visits/day. Non-reimbursed BH visits (same-day appointment with PC) contribute to productivity target even though they are not revenue generating.
MH/SA Services Provided	On-site Psychiatrist; Individual therapy; Groups – compulsive disorders (nicotine, alcohol, other drugs, gambling, binge eating, etc.), pain management, health promotion campaigns (depression, obesity, substance abuse)

Behavioral Health Service Volume, Patient Diagnoses, Referral Sources, and Reimbursement Sources.

In 2007, Golden Valley provided behavioral health services to 2,184 patients, averaging four visits of a 20-30 minute duration. There is no cap on the number of behavioral health visits. Ninety percent of the patients were referred to the BHC by a primary care physician, 7% were self-referred, and 3% were referred by a variety of community social service agencies.

Golden Valley is a clinic system operating several clinics across a broad geography. These clinics vary in terms of patient population and the mental health and addiction severity of patients. In clinic locations where county mental health service capacity is limited (e.g., Turlock), BHCs see a higher proportion of patients with severe mental illness and addiction disorders. In these clinics, brief treatments are more difficult to implement. Providers address severe mental illness as well as depression, anxiety, substance abuse, PTSD, parenting concerns, stress, and other life struggles. Individuals with Axis II disorders and those requiring longer therapy are hard to treat in the primary care setting which is designed for brief, solution focused interventions. In the integrated program, behavioral health clinicians work with primary care providers as a team to treat the whole person, addressing physical and mental health needs.

Behavioral Health Services Provided. Golden Valley offers individual and group therapy, addictions treatment, psychiatry services, crisis intervention services, pain management and health education program services. The Clinical Director of Behavioral Health Services is a Nationally Certified Addiction Counselor, which has been instrumental in bringing substance abuse treatment services to the clinic. GVHC offers group therapy for patients with compulsive disorders, which includes nicotine, alcohol, other drugs, food, gambling etc. The addiction treatment philosophy at Golden Valley focuses on the compulsive thoughts and behaviors associated with addiction that can be successfully addressed through a group therapy process, rather than developing groups based on substance/behavior of focus. This approach has been successful and de-stigmatizing for patients.

GVHC implemented a pain management program and protocol to better treat patients living with chronic pain. BHCs develop an agreement with the patient around pain management that is shared with the PCP and put in the medical chart. Golden Valley has an established relationship with Mercy Medical Center so that pain medication information can be tracked between the clinic and the hospital providers

for greater care coordination. GVHC acknowledges that treating chronic pain patients has been a challenge that needed to be addressed to minimize patient complaints and improve overall clinic competence in this area.

GVHC has a referral process to County Department of Mental Health (DMH) for patients with serious mental illness. Golden valley recently implemented quarterly meetings with DMH to understand the criteria for services (MediCal and definition of SMI) and improve the referral process. While awaiting services following a referral to DMH, BHCs provide a few sessions to SMI patients at the clinic to offer support.

Patient Expectations of Behavioral Health Services in Primary Care. The setting greatly affects patient expectations. There is a common perception in the mental health field that clients (and providers) will resist 30 minute therapy sessions because that is not long enough to provide therapeutic value. However, in the primary care setting, 30 minutes is a long time to have 1:1 clinical focus with a provider. As a result, GVHC has found that patients in the clinic setting actually do not expect sessions longer than 30 minutes. Culturally, the model (Brief Solution Focused therapy) works well with Latinos (60% of the population served at GVHC is monolingual Spanish speaking), especially Latino males who have the expectation of a quick turnaround. Patients wanting longer sessions have usually received services from the traditional mental health system and their expectations are different.

Recruiting and Hiring Behavioral Health Providers in Primary Care. A strategy that GVHC uses for hiring and financing behavioral health staff, as well as training and acclimating them to working in the primary care setting, is the California Perinatal Services Program, which is FQHC funded, and allows MSW (unlicensed) providers to bill for services delivered under the program. The annual salary for an MSW is typically \$25K less than an LCSW. GVHC hires MSWs to work in the CPSP program, which allows them to build skills in working with medical providers in the clinic setting, and knowledge of medical conditions, behavioral health education resources, and interventions while they are working on requirements for licensure. GVHC offers incentives for MSWs such as paying all the licensure and testing fees, and provide supervision.

Hiring the right behavioral health provider to work in primary care is critical to successful implementation of an integrated model. Taking a team approach to care requires a high level of accountability, transparency, and emotional intelligence among team members. Medical providers view BHCs as extension of themselves in the treatment process, but ultimately they are the primary provider responsible for the patient. Therefore if patient feedback is negative, the PCP is put in a difficult position with the patient, may lose confidence in the BHC, and thus slow referrals in the future.

The hiring process for behavioral health clinicians at GVHC has been strengthened to ensure goodness of fit. Interested candidates sign a confidentiality agreement with the Human Resource department, which allows them to shadow BHCs and get a feel for the nature, pace, and flow of work in the primary care setting. This process allows time for Golden Valley providers to assess the candidate's therapeutic presence in the clinic environment. Golden Valley has also developed a series of interview questions that provide important insight about a candidate. Questions include: *Tell us about a clinical mistake*

you have made? How did you rectify it? If a provider asks you a question about what medication to prescribe, what would you say? These types of questions allow a person to script themselves and reveal their instincts, which then allows supervisors to determine whether these instincts are congruent with the philosophy, ethics and needs of the clinic. Over the past 5 years since implementing this new hiring process, there has been no staff turnover among new BHC hires.

Screening Procedures. The PHQ-9 is used to screen for depression in patients who are geriatric, diabetic, or post-partum. The PHQ-9 is administered in the waiting room. Geriatric patients also get the mini mental status exam and are seen by a pharmacist, health educator, and a behavioral health provider. Children ages 4-17 are assessed using the Pediatric Symptom Checklist, and all children age 18-24 months are screened for autism.

The adult health history form is administered to all new patients and every five years thereafter through the registration packet. The health history form includes universal screening questions with 7 behavioral health items related to nicotine, alcohol, depression, anxiety, and domestic violence. This is the only universal screen administered to adults at Golden Valley; however the information collected is not systematically viewed or used by PCPs.

“Warm Hand-Off between Primary Care and Behavioral Health. During the warm hand-off, the PCP establishes the purpose of the visit, however there is variation across the PCPs regarding their involvement after the initial introduction between the BHC and the patient. BHCs adapt to the individual styles and preferences of the PCPs. Golden Valley finds that inclusion of the PCP in the warm handoff (to illustrate the team approach to care) is not as important as the BHCs skill in patient engagement in the initial moments after the introduction.

The warm hand off from PCP to BHC happens by cell phone and patients are prepared for this kind of interruption because it is part of the organizational culture. Because of the short term nature of these interactions, it would be unusual for the patient wait time to see a BHC to exceed 15 minutes. The community health center culture supports a normative wait time, so there is a higher tolerance at the clinic for waiting and interruptions.

Another factor influencing a patient’s willingness to wait is the preference for seeing more than one provider in one clinic visit. By seeing two providers in the same day, patients do not have to come back to the clinic for a follow up appointment and address child care and transportation issues. Because 40% of the patients are uninsured and self pay using a sliding scale, the same day reimbursement issue is not a problem. The sliding scale rate is \$30 per *visit*, which applies for all provider groups at the clinic (PCPs, BHCs, dentists, etc.). GV HC made the decision years ago not to charge a patient twice for same day appointments. Therefore, if a patient has a primary care appointment and a behavioral health session on the same day, they pay \$30 for a single clinic visit.

In situations where a same day visit is not possible and the appointment is scheduled for a different day, the demographic profile of the patients following through on the appointment changes to more women, English speakers, and higher mental health acuity. Latinos, males, and youth are less likely to schedule

different day follow up appointments. While the same day integrated visits do not generate revenue for the clinic, they do count toward the monthly productivity targets of the BHC staff.

Case Management. GVHC does not have a paid position dedicated to the provision of case management services. BHCs perform many case management duties, but these services are not reimbursable. When a patient needs case management services, the PCP will refer them to the BHC, who then relies on relationships with community-based providers for referral and linkage. In some cases, BHCs make 3-way calls with the patient at the clinic to assist with access to food stamps, housing, or SSI income benefits. BH providers build case management activities into their schedule, but this is non-billable time. GVHC does not have a system in place to follow up on referrals made to community-based services or track outcomes of referrals. Lack of capacity for case management is seen as a barrier to stabilizing patients with complex psychosocial needs and is a limitation in the service offerings in the CHC setting.

Information Sharing through Medical Records. BHCs track client progress on therapeutic goals in their case notes. However, only the PHQ-9 scores are entered into the electronic medical record, which is accessible to medical providers. In the EMR, there is a shared problem list that can be accessed by both primary care and behavioral health. Medical providers and BHCs also review patient progress during clinical meetings and there is an expectation of patient improvement after four sessions. After the 4th session, the provider team reviews the presenting problem, progress made and resolution. While there is a shared master *problem list*, one significant limitation is there is no shared or *integrated care plan*. Integration is not present in the IT system. IT/IS decisions are made by the leadership team (CEO, Chief Medical Officer, Chief Financial Officer, Chief Dental Officer, Human Resources, and Information Systems), but behavioral health is not directly represented so it is difficult to push the issue of developing an integrated care plan in the electronic medical record.

Communication & Coordination across Providers. GVHC made a deliberate decision not to have formal case conferences between medical and behavioral health providers for two reasons: 1) it is not financially feasible or sustainable to carve out an hour per week (or month) of the highest paid providers to conference around a very limited number of patients out of thousands; and 2) GVHC has a treatment philosophy that does not support having meetings about patient care when the patient is not present and participating in the discussion. Instead, GVHC focuses on integrated notes, email, and “instant messaging” on EMR when more than the note is needed. There is also strong emphasis placed on the BHC and PCP both talking to and in front of the patient when needed to communicate about treatment course. In addition, GVHC recently implemented “micro trainings,” which are bi-monthly and can be in person or by email (preferably both, for the same message). Micro trainings focus on procedural issues as opposed to clinical topic training. For example, instead of doing 30 minute trainings on addiction being a medical disease that requires a specific treatment protocol and referrals, micro trainings would focus very short, announcements and emails on the process for documenting addiction on the master problem list. When this is documented, the medical provider has established addiction as a primary disease, and therefore creates accountability for documenting actions taken to address this issue as part of the treatment plan.

Challenges Implementing Behavioral Health Services in the Community Clinic Setting. One of the implementation challenges related to clinical care is developing a consistent approach to the clinical session based on shared treatment priorities. The patient, PCP and BHC may have different perspectives of the presenting problem which complicates the treatment approach. For example, with a homeless patient with bipolar disorder and alcohol addiction, the PCP might prioritize treatment of bipolar symptoms, while the BHC may prefer to address the alcohol problem first, yet the patient might just want a housing solution. GVHC uses Motivational Interviewing in its counseling approach to put the patient's goals and readiness to address these goals at the forefront of treatment planning. However, clinical coordination continues to be a challenge when implementing an integrated, team approach to health care.

Core Components of Integration. GVHC identified the following core components of integration:

Proximity . GVHC believes services have to be delivered on site and, in their experience, a few hundred feet can change the impact of the referral. The further a patient has to go to access the next provider the less likely they are to follow through on a referral. Proximity drives the clinical protocols (referrals, communication, warm hand-offs, informal consultation etc.). Co-location facilitates knowledge transfer across discipline and builds professional relationships. Patients also carry information back and forth between providers, which helps clarify inconsistencies.

Psychiatric Consultation. In the absence of a strong relationship with County Mental Health and capacity for psychiatry and medication, having on-site psychiatry services is essential for IBH programs in CHCs. GVHC has experienced a culture change with the addition of a psychiatrist on staff. Psychiatrists and PCPs are able to communicate in a shared medical language, which increases the value of behavioral health services from the PCP perspective. The psychiatrists' knowledge and expertise with psychotropic medications brings credibility, status and parity to behavioral health services and elevated awareness of behavioral health issues. In hiring the psychiatrist, GVHC found that it was important to dedicate 10% time to training other medical providers.

Behavioral health presence beyond face-to-face provider time. The message of behavioral health needs to be available through means other than face-to-face encounters with the BHCs. There needs to be more of a population based approach, with educational resource materials and strategies for prevention. Written educational materials need to be available in all exam rooms and at nurses' stations. GVHC initiated health promotion and education campaigns starting with depression in 2008, obesity in 2009, and addiction in 2010. Behavioral health services should not disappear when the BHC goes on a vacation.

d) Innovative Project Goals and Accomplishments

For the IBHP Phase II Innovative Project, Golden Valley Health Centers focused on increasing medical provider awareness of substance abuse and compulsive disorders, increasing access to effective interventions for compulsive disorders, and implementation of pain management protocols and interventions. The following section highlights the goals and accomplishments of their Innovative Project implemented between October 2008 and September 2009.

Goal 1: Increase understanding and lower stigma regarding substance abuse and other compulsive disorders with primary care providers at selected Golden Valley sites.

- Developed a tool to measure the knowledge and skills, and attitudes of stigma of primary care providers regarding substance abuse and compulsive disorders.

Goal 2: Increase primary care provider skill regarding assessment and effective interventions for those with compulsive disorders at selected Golden Valley sites.

- Engaged primary care providers in on-going training

Goal 3: Develop a proactive pain management program, at selected Golden Valley sites, in part to assist with proper intervention for those who may have chemical dependency.

- Developed and piloted a new pain agreement and pain management materials that were implemented in all Golden Valley clinics

Goal 4: At selected Golden Valley sites, provide effective intervention for those patients assessed to have a compulsive disorder, where they would not otherwise received intervention.

- Initiated a compulsive disorders group
- Implemented a tool to measure effectiveness of the group, but did not collect sufficient data because the tool was too long and time consuming to administer in the group, and the literacy level was too high

Other Accomplishments:

- Established a very active and engaged pain management task force, consisting of clinical leaders at Golden Valley. The task force created a comprehensive pain management program, including organizational policies and protocols.
- Created a highly used behavioral health resource area on the Golden Valley intranet, with all approved patient screening tools, all new pain management materials, psychiatric emergency protocols, algorithms, and other resources.
- Expanded behavioral health capacity with the addition of 2 new behavioral health clinicians and another full time psychiatrist
- Strengthened a previously tangential relationship with two FQHCs in the Golden Valley catchment area by offering technical assistance for starting IBH services.
- Initiated a relationship with County Department of Mental Health through quarterly meetings to enhance communication and cross-system referrals.

3. Mendocino Community Health Clinic (MCHC)

a) Clinic History and Description

Mendocino Community Health Clinic provides comprehensive health services to the inland part of rural Mendocino County and the northern half of rural Lake County. Within the service area of 77,505 residents, MCHC has identified a target low income population of 30,439. In 2008, MCHC had 24,000 unduplicated patients with a total of 125,000 visits. MCHC operated three clinic sites and provides primary care, obstetrics, pediatrics, dentistry, psychiatry and behavioral health counseling services. Mendocino County is designated as a Medically Underserved Population (MUP) and Lake County is designated as a Medically Underserved Area (MUA). The population is mostly White (68%), and nearly a third (27%) are Latino. Approximately 40 percent of the service area population is low income at less than 200% FPL. Barriers to care include poverty, high unemployment rates and low per capita income, lack of affordable housing, lack of education and geographic isolation with minimal or no public transportation. Substance use and abuse of marijuana, methamphetamines, and opiates is common throughout the service area. Options for methadone replacement services no longer exist in Mendocino and Lake County. Suicide rates, drug induced deaths, and unintentional injuries are all significantly above state averages (about two times).

b) Motivation for Integration

MCHC's Medical Director, an ASAM certified addictions specialist was an early champion and supporter of an integrated approach to care and understood how it could improve patient outcomes. MCHC provided traditional mental health services and had already provide an integrated medical/behavioral health services within its Methadone Treatment Program. In 2003, with consultation from Open Door Clinic who had implemented a Strosahl model, Mendocino Community Health Clinic (MCHC) brought all of its mental health services under the primary care roof. With a primary care patient population with significant rates of substance abuse and mental health issues, medical providers quickly embraced the additional support and communication that did not exist when service delivery was more siloed. Finally, many patients were more willing to accept a "behavioral health referral" from their primary care provider than a referral from an outside mental health provider. As reported in many counties, many patients experience stigma associated with traditional mental health services, and were reluctant to access these services from the county. MCHC can provide behavioral health services for patients with less severe conditions in a clinic setting with less associated stigma.

c) Approach to Integrated Behavioral Healthcare

Mendocino Community Health Clinic IBH Model Features

Title of BH Staff	Primary Care Counselors (PCC)
Patients Seen/Day	To achieve cost neutrality, providers see 8-13 patients daily
Population Served	The most common behavioral health diagnoses include major depression, anxiety, substance abuse, and PTSD.

Productivity Incentives	Providers can achieve incentives after the 7th visit; however incentives are being re-evaluated to include better quality and outcome measures.
MH/SA Services Provided	Brief integrated behavior health counseling and traditional psychotherapy, Buprenorphine program for opiate addiction, chronic pain program 2 full-time psychiatrists, case management support provided by county through MHSA. Individual and family session, psychoeducational classes, linkages to community resources.

Behavioral Health Service Volume, Patient Diagnoses, Referral Sources, and Reimbursement Sources.

MCHC provided behavioral health services to over 2000 patients in 2009. The most common behavioral health diagnoses included major depression, anxiety, substance abuse, and PTSD. Per patient visits averaged four to five visits and sessions averaged between 20 and 30 minutes. MCHC Behavioral Health Department utilizes a 12-session practice model with the ability to extend based on medical necessity. Most (84%) of patients are referred by PCPs, 11% are self referred, and 5% are directly referred by County Mental Health and Agencies; however anecdotal and historical evidence suggests the percentage of county referrals is higher, but are not systematically or formally referred by the county.

Behavioral Health Services Provided. MCHC is committed to providing a high level of service to community members including primary medical care, counseling and psychotherapy, and psychiatry services. MCHC provides both individual and more recently psychoeducational classes. Behavioral health strategies include cognitive-behavioral, motivational interviewing, relational, problem-solving therapy, psycho-education, mindfulness, stress reduction / depression management and medication management with psychiatry. Data from MCHC’s EMR is being reviewed to manage care. In addition, at the twice monthly integrated care meetings, a patient registry for Buprenorphine and chronic pain is used to manage care.

While MHCH was formally introduced to the Strosahl model in 2003, over the course of implementation, they found that the 20-minute brief session was not realistic given patient needs. Even in a primary care setting, it was not feasible to introduce a screening instrument, provide health education, offer the patient resources and provide needed counseling in 20 minutes.

MCHC’s behavioral health department subscribes to the research on early change in treatment that if a particular treatment approach delivered in a given setting by a specific provider is going to work, most often there should be measureable improvement earlier rather than later in care. MCHC is incorporating a Client Directed Outcome-Informed Model, which relies on real-time feedback from patients about treatment effectiveness to improve outcomes using a Session Rating Scale (SRS), which rates the therapeutic alliance and an Outcome Rating Scale (ORS), rating overall functioning. The integrated care model at MCHC includes a multi-disciplinary case conferencing meeting which focuses on the patient’s health status, improving provider communication, and providing medication management that is both medically appropriate, patient tolerated and behaviorally effective with input from multi-disciplinary providers.

Screening Procedures. MCHC delivers a universal biopsychosocial screening instrument which incorporates PHQ-2, domestic violence, substance use, and other health behaviors questions annually. Thus far, attempts to apply a universal instrument by medical and behavioral health outside of the

annual biopsychosocial like the PHQ-9 have not been entirely successful. Currently, behavioral health staff utilizes the PHQ-9 and Pain Self Efficacy Questionnaire every three months.

Examples of screening and assessment instruments commonly used by the BH providers include:

Global Functioning: 1) Session Rating Scale/Outcome Rating Scale (4-items); 2) Subjective Unit of Distress (SUD): Assesses symptoms and readiness for behavior change

Depression/Mood Assessment Instruments: PHQ-9, Mood Questionnaire (13 items); Overall Anxiety Severity and Impairment Scale (OASIS-5 items)

Substance/Alcohol Use: CAGE/CAGE-AID;

Pain: Pain Self-Efficacy Questionnaire (PSEQ) 10 item (Assess confidence in performing activities while in pain and the degree of avoidance/interference with work and social function)

“Warm Hand-Off” between Primary Care and Behavioral Health. At MCHC, behavioral health providers schedule 12-13 visits per day, but the no-show rate is quite high (25%). Warm hand-offs occur infrequently and typically when a BHC has a patient no-show. Warm hand-offs are also limited because of availability of a counselor and the inability to capture revenue for the service. PCPs and BHCs work with the patient to schedule a follow up appointment the next day whenever possible.

Case Management. MCHC recognizes the need for case management services, but like most community clinics, they find it very difficult to finance. Currently, MHSA funds pay for a part-time county case manager to work with patients identified with significant mental illness receiving services at the clinic. Traditionally, MCHC has relied on grants to fund case management, but when grant funding ends, this function is politically vulnerable in the clinic setting. In attempting to build the case for case management services, MCHC is interested in tracking several measures: productivity of medical providers before and after implementation of case management services; patient satisfaction; no-show rates; referrals to other social service systems; and provider satisfaction.

Information Sharing through Medical Records. Medical providers and BHCs have integrated charts and MCHC is currently implementing EMR which will enhance data tracking, outcome measurement and information sharing across all service disciplines. MCHC has a registry for Buprenorphine and chronic pain patients on opiates and is working on chronic disease registries for patients with SPMI and diabetes.

Communication & Coordination across Providers. Integrated case conferencing is considered an essential ingredient for successful IBH implementation. MCHC holds regular twice a month patient care meetings between medical and behavioral health providers to discuss treatment progress as well as care coordination.

Challenges Implementing Integrated Behavioral Health in the Community Clinic Setting. MCHC considers Electronic Health Records a critical strategy for linking providers and clinics across discipline. MCHC also considers case management services a core component of an integrated service model, even though this function is not reimbursed in the community clinic setting. As patient mental health and addiction severity increases, case management services become more critical. MCHC has had limited and inconsistent infrastructure to provide case management services and has often relied on small

grants for funding. Nevertheless, this is a component of integrated behavioral health that MHCH advocates for strongly – internally as an organization and within the broader field.

Core Components of Integration.

Core components of the integrated service model at Mendocino Health Clinic include: co-location and close proximity of primary care and behavioral health providers, cross-system collaboration (administrative/medical/BH), regular POD meetings, integrated case conferencing, data sharing, and outcome tracking. Other essential components to a successful integrated service model, which MCHC is currently working to strengthen, include case management and implementation of EMR.

At MCHC, integrated behavioral health is not a program – it is an approach to providing care to patients in the community. Integrated behavioral health also is a calling card for provider recruitment and, while providing integrated services requires constant coordination and communication, MCHC is clear they would never go back to a non-integrated model of care.

d) Innovative Project Goals and Accomplishments

For the IBHP Phase II Innovative Project, Mendocino Community Health Clinic focused on decreasing opiate use for patients in the Buprenorphine program, increase collaboration between medical and behavioral health providers for patients in this program and improved the identification of depression for these patients through enhanced screening. The following section highlights the goals and accomplishments of their Innovative Project implemented between October 2008 and September 2009.

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Goal 1: Decrease abuse of illicit and non-prescribed opiates by increasing the number of patients in the Buprenorphine program.

- Significantly exceeded goal for reducing non-prescribed opiates. Ninety percent of patients in the program had negative urine toxicology within 90 days of program enrollment.
- Created a unified electronic registry to track urine toxicology results, depression scores, and dates of previous and follow-up visits by provider, which was used as part of regular case management meetings to improve treatment outcomes.

Goal 2: Increase the coordination of care between medical and behavioral health providers for Buprenorphine patients.

- Established routine staff meetings, two integrative care meetings, and documented case conferencing.

Goal 3: Identify and appropriately treat Buprenorphine patients with co-occurring depression.

- Developed and implemented clear protocols for referral, screening, and enrollment that are used by providers.

Goal4: Implement new touch-screen technology for administration of PHQ-9

- Overall, there was generally poor compliance among providers treating patients in the Buprenorphine program.

Other Accomplishments:

- Improved the integration of behavioral health and medical processes and contributed to an increase in behavioral health visits.
- Created a framework and infrastructure for building a Chronic Pain Program
- Contributed to the recruitment of 2 new psychiatrists.

4. Open Door Community Health Centers (ODCHC)

a) Clinic History and Description

The Open Door Community Health Centers (ODCHC) service area is in the Northern California counties of Humboldt and Del Norte. The region served by Open Door is designated as a Medically Underserved Area and a Health Professional Shortage Area for primary care, dental and mental health care. The racial and ethnicity composition is primarily white (84%), with six percent American Indian, and seven percent Hispanic. More than eight percent of the population is non-English speaking, with Spanish being the prominent non-English language spoken. ODCHC provides the majority of primary medical and almost all of the dental care for the low-income, uninsured and publicly insured patients. In addition, ODCHC provides prenatal and obstetric care, HIV/AIDS treatment and management, and increasingly becoming the primary mental health care for the county.

In 2007, ODCHC served 32,836 patients with 158,000 encounters. Ninety percent of the patients seen are under 200% of the Federal Poverty Level (FPL) and 60% are under 100% FPL. Half are on public insurance (Medicare accounts for 9%, Medi-Cal is 33%, CMSP is 7%), 31% are uninsured, and 19% have private insurance.

b) Motivation for Integration

There were both financial and clinical motivations to integrate behavioral health services into primary care. Open Door was one of the first clinics in the nation to implement the Strosahl model because the Executive Director was attracted by the evidence that the model could increase revenue for the clinic through greater productivity of the medical providers. The medical providers bought into the Strosahl model because of the opportunity to improve the quality of care and ultimately improve client outcomes. .

c) Evolution of Open Door's Approach to Integrated Behavioral Health

Over the past nine years, the integrated behavioral health model at Open Door has experienced three distinct phases: 1) Implementing an Evidence-Based Practice (EBP) model; 2) Adapting the EBP to work in the real world; and 3) trying to maintain integration during the economic crisis.

Phase I-- Implementing the Evidence-Based Practice. Based on the Strosahl model, leadership at ODCHC developed an integrated behavioral health care manual and conducted a two-day, all staff training on the new model of care. There was overwhelming buy-in by nearly all of the staff, with the exception of a few LCSWs. These providers were not comfortable with the 30 minute therapy session and ultimately left the clinic. These positions were filled with LCSWs that received training directly from Dr. Strosahl. They developed educational fliers to inform the PCPs of the role of the BHC. In addition, they relied entirely on the warm handoff from PCP to BHC and did not schedule any appointments for the initial

behavioral health visit. The model relied on a brief, short-term treatment model, with an average of 4 behavioral health visits per patient.

Phase II – Modifying the Strosahl model to work in the context of the local community. Due to workforce shortage issues in the region, Open Door was unable to operate the program with just LCSWs, so they hired psychologists. At this point, ODCHC began scheduling two types of appointments: 30 minute therapy sessions and 45 minute Eye Movement Desensitization and Reprocessing (EMDR) therapy sessions. The decision to increase the number of scheduled visits was implemented because of the inability to reimburse for the same day warm handoff and the desire by Administrators for the program to achieve cost neutrality. Brief therapy sessions and a short-term intervention model were less effective given the growing needs and complexity of the patient population. A short term therapy model (4 to 6 sessions) was particularly ineffective with clients with serious mental illness, Axis II Disorders, and addiction disorders. BHCs could extend the number of sessions to more than 6 after a referral back to the PCP for further assessment.

In trying to strike a balance between the need for warm hand offs and scheduled visits, Open Door tried multiple strategies for making referrals from the PCPs to the BHCs, including in-person warm hand offs, using pagers, cell phones, or by slipping a referral form under the door. The clinic finally landed on an informal “flagging system” where the BHC hangs either a red or green flag on the door indicating if they can be interrupted. The issue was finding an appropriate way for PCPs to make a referral to BHCs without interrupting EMDR sessions. EMDR has proved to be an effective short term treatment intervention at Open Door, but these sessions cannot be interrupted. Coordinating the schedule of available BHCs using the flagging system created better balance between scheduled visits and accessibility for the warm hand off.

Phase III – Maintaining an integrated behavioral health program during the economic crisis. The economic downturn and the impact of the budget crisis on County Mental Health have significantly affected Open Door’s integrated behavioral health program. There is currently a hiring freeze at Open Door, despite having 3 open BHC positions. The decimation of funding for county mental health services is forcing an increased number of clients with serious mental illness to seek treatment at community health clinics. Open Door has seen a dramatic increase in the number of patients with serious mental illness accessing services at the clinic. It was the original intent of ODCHC to transfer clients with more serious mental health conditions back to county mental health in order to focus more on prevention services (e.g., behavioral health treatment for diabetes). However, the county has limited capacity to take these clients back into their system. As such, the behavioral health program, by necessity, currently focuses more resources on treating people with serious mental illness than implementing behavioral health services targeting prevention. ODCHC would ideally prefer to focus health promotion services on patients in Quadrants 1 & 3, but service demands require BHCs to provide longer-term treatment for patients in Quadrants 2 & 4.

The average number of BH visits has increased over time, from an average for 4 visits in the first year to 6 visits, and the average is still rising. MediCal limits behavioral health visits to 12 per person unless there’s medical necessity. At Open Door, the number of clients reaching the 12 visit limit is increasing,

requiring case conferences to determine medical necessity. BHCs are starting to recognize frequent users of the behavioral health program who really need case management services rather than behavioral health therapies.

As a result of the hiring freeze and the increase in demand with fewer staff, BHCs are booked 6 to 8 weeks out. There is less communication and fewer hallway consultations between medical and behavioral health providers because everyone is so busy and overbooked. Outside of the case conferences to determine medical necessity for continued treatment, PCPs and BHCs have limited interaction around patient care. There is limited time and opportunity for warm hand offs and no show rates are increasing. The system is no longer a truly integrated system that is coordinated across providers and responsive to clients. The economic crisis has posed a significant threat to the integrated care model at Open Door, and without another evolution, they believe they run the risk of reverting back to a parallel care system.

d) Current Integrated Behavioral Health Model Features

Open Door IBH Model Features

Title of BH Staff	Behavioral Health Consultant (BHC)
Patients Seen/Day	To achieve cost neutrality, see 9 patients daily
Population Served	60% of patients receiving behavioral health services have a diagnosis of schizophrenia, schizoaffective disorder, or bipolar or unipolar depression.
Productivity Incentives	Productivity incentives are based on a monthly average; can be achieved with 6 visits daily.
MH/SA Services Provided	On-site Psychiatrist; Individual therapy; EMDR; Groups – pain management (“Managing Pain Before it Manages You”), wellness (managing chronic illness); diabetes management; weight loss; anger management; anxiety; PTSD; Buprenorphine); diagnosis specific peer support groups; mobile medical Suboxone treatment for homeless

Behavioral Health Service Volume, Patient Diagnoses, Referral Sources, and Reimbursement Sources.

In 2009, ODCHC provided 7,982 behavioral health services to 1,587 unduplicated patients. All patients were referred by PC providers. The average number of visits is 6 and visits are capped at 12 unless medical necessity is determined. The average length of visits varies; initial consult is 60 minutes and follow up is 30-45 minutes. Nearly two-thirds (60%) of patients receiving behavioral health services have a diagnosis of schizophrenia, schizoaffective disorder, Bipolar Disorder, or Major Depression.

Behavioral Health Services Provided. The Integrated Behavioral Health Program began at ODCHC in 2002 and is currently available to all seven primary care facilities. Behavioral Health Consultants (BHCs) serve as consultants to the referring PC provider as part of a holistic model of healthcare. The clinics achieve behavioral modifications and prevention with a short term therapeutic model using cognitive behavioral therapy (CBT) and skill-based interventions such as Eye Movement Desensitization and Reprocessing (EMDR) therapy. In addition to individual therapy, ODCHC provides group therapy, psychiatry services and mobile medical services that offer Suboxone treatment for homeless individuals.

Group Therapy. ODCHC believes that offering groups enhances integration because the curricula and education programs can be used across disciplines. Groups also are an effective way for behavioral health staff to become educated on medical and chronic illness issues. ODCHC operates 4 groups that

are co-facilitated by a physician and a BHC once a month for an hour. These include: Pain management, Wellness, Diabetes, and Buprenorphine. To bill for the groups, the physician meets with each individual, checks vital signs and reviews prescriptions, and writes notes on each individual group participant. For the Buprenorphine group, a structured curriculum from the Substance Abuse and Mental Health Administration is used, focusing on education and rebuilding self-esteem. Patients enjoy these groups because of the multi-disciplinary approach and the truly integrated facilitation of medical and behavioral health elements in the curriculum. Three groups (anger management, anxiety, and PTSD) are run by the Behavioral Health team, which includes a BHC and the psychiatric nurse practitioner for medication management. There is also a weight loss group that is facilitated by a BHC. In addition to formal therapeutic groups, ODCHC also operates weekly diagnosis specific peer support groups. While not directly revenue generating, providing infrastructure to host these peer support groups fills a community need and promotes access to the clinic for participants.

Screening Procedures. The PHQ-9 is used for diabetic patients, but not for other populations because it is difficult to get PCP buy-in to use the screens. Open Door is in the process of implementing an electronic medical record system that includes 15 different behavioral health screeners. They will develop a protocol to assist medical providers in knowing who and when to screen.

“Warm Hand Off between Primary Care and Behavioral Health.” There are two paths to referral from the PCP to the BHCs: Referral (non-acute/no crisis) with follow-up appointment or Warm Handoff (acute symptoms) to BH Consultant who does an immediate consultation, stabilization, and plan of care within the clinic system or to community resources. With the increasing demands on the BHCs, there have been far fewer opportunities for warm hand-offs with the exception of crisis situations. With BHCs being booked almost 8 weeks out, behavioral health services are not as accessible to patients with non-acute needs and no-show rates have increased.

Case Management. The need for case management is directly correlated with the severity of the mental health needs presented at clinic. Case management has become an essential element of the behavioral health program as the proportion of individuals with SMI increases at Open Door. However, case management is not a reimbursable service at FQHCs. To fill the case management role, Open Door has tried various strategies, including using MSW interns from Humboldt State University, which did not work for two reasons: 1) interns were spread too thin across the geographically distant clinics in the system, so did not have enough time to provide consistent services; and 2) interns are on an academic calendar that resulted in poor continuity of care for providers and clients.

Absent sufficient resources for case management, when the acuity of the mental health problems in the patient population escalates, the clinic experiences an increase in the number of crisis cases. Primary care providers immediately hand crisis situations over to the behavioral health staff. Crisis intervention takes precedence over treatment of the physical illnesses. As a result, the physical health needs of the population with acute mental health needs are not adequately addressed.

Open Door is in the process of piloting a program that pairs a case manager with a psychiatric nurse practitioner at 1 site to demonstrate the effectiveness of this position at the community health clinic. In

the pilot program, ODCHC is targeting the case management caseload at 50 patients. ODCHC intends to illustrate the return on investment for case management through increased productivity and billability of the other providers. The nurse practitioner would conduct the psychosocial assessment so that the psychiatrists are free to see more clients for medication management. The case manager will provide benefits advocacy to connect uninsured clients to MediCal, CMSP, or Medicare Part D, which could have a significant financial impact on the clinic. Data measures will include: show rates, cycle times, access to PCPs after BH, provider satisfaction, patient satisfaction, and improvements in mental health outcomes.

Information Sharing through Medical Records. Open Door is currently implementing Electronic Medical Records. Dr. Julie Ohnemus, Medical Director at North Country Clinic, is currently building a behavioral health module for EMR in collaboration with representatives from Oregon and Washington. Expectations are high that moving to EMR will enhance care coordination across provider groups and enable great health and behavioral health outcome tracking. EMR also has the potential to track outcomes of upcoming case management pilot program.

Challenges Implementing Integrated Behavioral Health Services in Community Clinic Setting. In addition to the challenges of maintaining an integrated model during times of fiscal crisis, ODCHC identified workforce and legal issues that introduce challenges to successful implementation. Staff turnover is not uncommon, therefore, standardized program materials and manuals are necessary to train new program staff to maintain an integrated model of care. In addition, on-going reinforcement training for BHCs is important for maintaining consistency and quality of care in a primary care setting.

CEO and administrators need education and technical assistance on the legal considerations of integration based on the mandatory reporting requirements and ethics considerations for mental health professionals. Some of the legal issues that need operational clarification include: record keeping, how to address “abandonment” in primary care settings, HIPAA interpretations, assessment of danger to self and others, and maintaining confidentiality.

Core Components of Integration. ODCHC believes that to maintain an integrated model, a clinic must be flexible, responsive to patient needs, and willing to adapt the health care delivery system to an evolving political and fiscal environment. Understanding the concept that “all health care is local,” ODCHC continues to modify their approach to integrated behavioral health based on the needs of the community. In response to the growing SMI population seen at the clinic, Open Door has leveraged IBHP funding to expand the behavioral health program to include psychiatry and case management services, with a goal of demonstrating positive outcomes to ensure financial sustainability. While the current program faces challenges, the value of integrated behavioral health has already been established at Open Door and is not in jeopardy of losing this distinction. Certain core elements are essential to integrated behavioral health, and these components are listed below.

ODCHC identified the following core components of integration:

- Co-location
- Treatment philosophy that behavioral health is essential to patient care
- Buy-in from clinic leadership

- Universal screening to identify behavioral health conditions and put them at the forefront of the treatment plan
- Communication and training across PC and BH providers
- Program design and infrastructure is in alignment with needs of population served
- Financial support for vital functions (technology, case conferencing, same day visits, and case management)
- Information sharing through medical records and case conferencing
- Data tracking to demonstrate clinical outcomes (registries, I2I)

e) Innovative Project Goals and Accomplishments

To respond to a growing patient population with complex mental health needs, Open Door Community Health Center used their funding from IBHP Phase II Innovative Project to build clinic capacity to provide psychiatry services. In addition to increasing access to psychiatry services, they also focused improving the physical health outcomes for SMI patients through greater identification and treatment of metabolic syndrome. The following section highlights the goals and accomplishments of their Innovative Project implemented between October 2008 and September 2009.

Goal 1: Build the psychiatry arm of the integrated behavioral health program and ensure its financial sustainability.

- Hired three new staff: 1 psychiatrist, 1 psychiatric nurse practitioner, and 1 RN with significant mental health experience
- Reviewed and revised behavioral health manual, program policies, and protocols
- Disseminated information regarding psychiatry team and services to the Board, Executive Team, and all clinic sites
- Developed an excel cost center tool to monitor behavioral health program costs, however this is not yet used to monitor program costs on a routine basis
- Survey PCPs on satisfaction with psychiatric services at baseline and semi-annually; however, the response rate was too low to produce reliable results
- Since the inception of the psychiatry program, the number of crises has declined and the medical provider satisfaction has increased. Now it is difficult to imagine the clinics without the psychiatry program.

Goal 2: Improve the physical health of the serious mentally ill served by Open Door by increasing access to physical and psychiatric services through the psychiatry team.

- Conducted an analysis of clinic data to identify co-morbidities and modifiable risk factors of SMI leading to early “natural causes” of death. Of the 1790 unique SMI patients, only 383 had identified co-morbidities suggesting that PCPs likely under-diagnose chronic disease in this population.

- The SMI/co-morbidity analysis identified diabetes as the most common co-morbidity in Open Door's SMI population (individuals with schizophrenia, schizoaffective, bipolar, and unipolar depression).
- Individuals with SMI have an assigned PCP and Open Door is their medical home.
- Of the SMI, 50% were identified with the potential for or actual diagnosis of metabolic syndrome.
- Following a study published in the Annals of Family Practice, pedometers were distributed to a sample of 10 SMI patients. Individuals in this group lost an average 2.72kg compared to a loss of 1kg in the published study.
- Psychiatrists presented two educational forums on bi-polar diagnoses with usage of mood screening tools and tips for choosing and using mood stabilizers effectively. Trainings were video conference to PCPs in clinics throughout the two county area.

Other Accomplishments of the integrated behavioral health program:

- Developed a standardized approach to assist PCPs address insomnia, which resulted in a 65% increase in referrals to BHCs for insomnia treatment.
- As a result of hiring an in-house psychiatrist, re-established a relationship between Open Door and Humboldt County Mental Health. The Open Door psychiatrist is networking with other local psychiatrists by offering educational seminars and attending their meetings.
- Developed an RN triage protocol for serious mentally ill patients that present at the clinics in crisis. This protocol includes a "code purple" to summon specific staff to the crisis scene.
- The curricula and structure of the Buprenorphine and Pain Management Groups were shared with other IBHP clinics (Golden Valley, Mendocino, and San Diego CCC) and adapted for use in their communities.

5. Sierra Family Medical Clinic (SFMC)

a) Clinic History and Description

Sierra Family Medical Clinic (Miner's Health Center and Western Sierra Medical Clinic) is located in rural Nevada County and has been in operation since 1982. SFMC is a full-service medical, behavioral health, and dental clinic facility that meets the primary healthcare needs of area residents. The community has a significant low income population and is a designated medically underserved population. The barriers to care include transportation, poverty, lack of education, fear of preventive medical care (e.g., immunizations and fluoridation), and counter culture attitudes and behaviors. Of the 3,219 patients served in 2007 73% are under 200% of the Federal Poverty Level. In terms of insurance coverage, 12% are Medicare patients, 46% are Medi-Cal, CMSP, and Healthy Families patients, and 24% are uninsured. SFMC is the only vanguard clinic that specifically references integrated care in their clinic mission statement: *"The mission of Sierra Family Medical Clinic, Inc. (SFMC) is to provide quality integrated primary medical, dental, and behavioral health care to all persons of Nevada County and surrounding communities regardless of age, sex, race, color, national origin, religion, disabilities, or ability to pay."*

b) Motivation for Integration

At Sierra Family, motivation to provide behavioral health services stems from a desire to improve the quality of care and be responsive to the needs of patients in this community. There is a tremendous demand for integrated behavioral health services at the clinic. SFMC conducted a universal screen of various health and mental health conditions to understand prevalence rates in the patient population and plan services accordingly. SFMC discovered that 25% had depression, 30% had generalized anxiety, 10% had bipolar disorder, 8% had issues with alcohol use and 5% had diabetes. The clinic realized they were spending a considerable amount of time and resources treating diabetes, but other conditions that have a significant impact on the individual and the health care system, such as depression, were not being addressed sufficiently.

PCPs faced growing demands on their time based on the complexity of problems presented in the community clinic setting that required a behavioral health component. PCPs simply did not have time to address patient education, positive behavior change such as exercise, nutrition, and smoking cessation during the clinical visit given increased patient demand and higher patient flow in the clinic. A Behavioral Health Consultant (BHCs) was introduced to the clinic in 2002 to assist the PCP in providing a broad array of medical, behavioral and health education services/resources to the patient. SFMC experienced a "sea change" in their medical practice – one where managing complex patients without behavioral health services available on-site was no longer practical or possible.

Pain Management

Effectively working with chronic pain patients is a challenge all community health centers face, which provided additional motivation for SFMC to integrate behavioral health services. Introducing behavioral health services through pain management programs is an effective strategy for clinics new to integrated behavioral health because of the need for additional support with this population. Patients with chronic pain need more than just access to prescription medication. For many patients, pain relief is not the primary goal – it is improved functioning. BHCs are instrumental in helping patients understand how to manage their symptoms physically and emotionally, which leads to improvements in coping skills and overall functioning. BHCs address behavior changes that are necessary for patients to increase accountability and adherence to care plans. Successful management of the behavioral issues in addition to appropriate prescription monitoring and management can lead to reduced conflicts and complaints.

Stigma Associated with Substance Abuse Treatment

Sierra Family was further motivated to integrate services so that community members could access needed substance abuse services in a setting with more anonymity and lower social stigma. Limited resources exist in rural areas for substance abuse treatment. Effective addictions treatment requires more than a unilateral approach from a PCP. Offering a one-stop-shop integrating medical, dental, mental health, and substance abuse treatment “under one roof” also reduces the stigma often associated with AOD treatment, especially in rural areas where “everyone knows whose car is parked in the parking lot.”

c) Approach to Integrated Behavioral Healthcare

Sierra Family IBH Model Features

Title of BH Staff	Behavioral Health Consultant (BHC)
Patients Seen/Day	8-10/day (9-10 = cost neutral); no show rate 20%
Population Served	Bipolar, PTSD, Depression, Anxiety; provide medical home to 1000 SMI in the county to manage physical side-effects of medication and metabolic syndrome
Productivity Incentives	None
MH/SA Services Provided	Individual counseling (CBT/brief solution focused therapy; lifestyle management (i.e., weight loss, smoking cessation, chronic pain management, depression management, and diabetes compliance); couples counseling; family communication; parenting skills; ADHD treatment for children and adults; relaxation/yoga/meditation; AoD services using 12 step model; Telepsychiatry, on-site psychiatry services from county mental health one afternoon/week

Behavioral Health Service Volume, Patient Diagnoses, Referral Sources, and Reimbursement Sources.

SFMC provided behavioral health services to 467 unduplicated patients in 2007. The average number of visits was 6, with sessions averaging 20-30 minutes in length. There is no cap on the number of visits. The majority (80%) of the patients are referred by the PC providers (19% self-referral, 1% other). Three-quarters of the population using behavioral health services have serious mental illness and four percent have substance abuse issues.

Behavioral Health Services Provided. Sierra Family offers an array of mental health services, including individual and couples counseling (e.g., CBT and brief solution focused therapy), parenting skills and family communication, ADHD treatment and education, relaxation/yoga/meditation, and life style

management. The lifestyle management interventions address a variety of issues including weight loss, smoking cessation, depression management, chronic pain management, and diabetes compliance. Alcohol and drug treatment services are available on-site two days a week through a collaboration with a community substance abuse agency (Common Goals) that uses a 12 Step treatment model. The program also serves individuals with court mandates (CPS and probation) for substance services. Through this partnership, there is a reciprocal referral policy for substance abuse and medical services between Sierra Family and Common Goals.

Screening Procedures. All adult medical and dental patients are administered the Modified Mini Screen for co-occurring disorders at the first visit and annually thereafter. The screening instrument is administered by the medical assistant as part of the registration packet. The medical provider administers the PHQ-9 to screen for depression and the MDQ for patients with anxiety or depression as a quality assurance measure to rule out bipolar disorder prior to prescribing psychotropic medications.

“Warm Hand Off” between Primary Care and Behavioral Health. The “warm hand-off” is a cornerstone of the SFMC integrated behavioral health model. When the PCP has a patient they would like to refer to the BHC, a referral form is slipped under the office door of the BHC with vital information including patient location, insurance status, specific issue (life management, mental health, etc.), and level of urgency (emergency or first available). The PCP makes the introduction between the patient and BHC and establishes the purpose of the encounter. At Sierra Family, it is important for the patient to witness the collaboration and team approach to care that occurs during the warm hand-off process between the medical and behavioral health providers. SFMC developed a training DVD on the warm hand-off, which is available on YouTube. The DVD features several warm hand-off case study vignettes, including: “Patient with New Bipolar Diagnosis,” “Patient with Type II Diabetes,” “Weight Loss Patient,” “and Patient with Depression and Anxiety,” “ Patient with Insomnia,” etc.

Case Management. SFMC contracts with a case manager one afternoon a week that has specific expertise working with individuals with mental illness. The case manager provides referrals to community services for benefits counseling, food stamps, homeless shelters, as well as connections to group and peer counseling. The case management position is funded through a small community resource connection grant through the County Mental Health agency. BHCs perform many of these duties when the contracted case manager is not on site.

Information Sharing and Communication. SFMC has an integrated medical record, but all staff are using paper charts. SFMC is quite small and can rely on informal processes for information and communication. There are a total of 6 medical providers in the clinic, and the CEO, Dr. Peter Van Houten, started the clinic in 1982 and has been the Medical Director continuously since then. There is one BHC and she has been at Sierra Family since the clinic started providing integrated services in 2002. At this point, most patients referred for behavioral health services are already familiar with the BHC and the close collaborative relationship among the SFMC staff.

Challenges Implementing Integrated Behavioral Health Services in Community Clinic Settings. Medical provider resistance has challenged the process of implementing behavioral health services. Achieving

buy-in from medical providers can be a long and slow process. Providers require training and education to fully understand the utility of integrating behavioral health services. Medical providers often want to do it all and believe they have the skill set to do it all, which makes them reluctant to hand off the patient to another provider. To achieve greater buy-in from medical providers, SFMC has found that it is important to emphasize quality of care for the patient and the increase in time the physician will experience by leveraging the skill set of other team members.

Core Components of Integrated Services Model. SFMC identified the following core components of a successful integrated services model:

Medical Provider Buy-In: Providers need to genuinely believe that providing behavioral health services is in the best interest of the patient, enhances the quality of care, and improves provider and clinic productivity.

BHC Skill Set: BHCs need to know how to adapt to the primary care setting and be comfortable providing brief, solution focused therapy. Additionally, they need to be flexible in terms of dealing with the physical acuity of the population, as well as the environment where interruptions are the norm.

Administrative Buy-In: Administrators need to understand that revenue neutrality takes time and likely will not occur in the first couple of years. They also need to understand the true costs of running the program to set realistic productivity targets for BHCs. Integrated behavioral health improves quality and productivity. Indirect costs and the infrastructure (e.g., receptionist time, paperwork) for a behavioral health program are relatively low compared to adding a new primary care provider.

Difference between co-location and a fully integrated care model: While co-location is important, it is not sufficient for integrated care because vital communication between the PCP and the BHC is limited. A fully-integrated team approach to care is more than just a referral to the behavioral health provider. Behavioral health services are an essential aspect of the clinical care package. A fully-integrated approach fosters a mind-body connection by approaching disease management, lifestyle management, and pain management from both a medical and psychological perspective.

d) Innovative Project Goals and Accomplishments

For the IBHP Phase II Innovative Project, Sierra Family Medical Clinic focused on increasing provider training in psychopharmacology, improving access to case management and substance abuse treatment services and developing training material for dissemination. The following section highlights the goals and accomplishments of their Innovative Project implemented between October 2008 and September 2009.

Goal 1: Provide training in psychopharmacology for all medical providers.

- All medical providers were supplied PDAs through Northern Sierra Rural Health Network using MHA funding.
- Training in psychopharmacology to the Northern Sierra Health Network was provided by Sierra Family

- Sierra Family worked with the Northern Sierra Health Network and county mental health to create a strategy for assessing the overall change in the attitudes and comfort level of providers with psychopharmacology

Goal 2: Decrease Behavioral Health no-shows by 30%

- Offered patients gas vouchers
- Analyzed no-shows by payer type to identify patterns among patients with the highest rates. Assess these by zip code to determine if distance is a barrier.

Goal 3: Increase provision of substance abuse treatment to at least 20 patients receive individual or group treatment by December 1, 2009.

- Substance Abuse treatment was integrated into the clinic and 20 patients received services
- Collaboration with Common Goals (community-based SA provider) developed and Common Goals provides group treatment on-site two days/week
- Random drug screening conducted for patients in the pain management program is available for the SA treatment population treated through the Common Goals program

Goal 4: Establish case management services four hours/week

- Case Manager provides services one afternoon/week, including health education, psychosocial support to children, adults, and families

Goal 5: Develop and disseminate training on integrating services.

- Developed DVD on the Warm Hand Off process and disseminated copies of the DVD
- DVD material is now available on YouTube as a four-part series

Other Accomplishments of the integrated behavioral health program:

- In November 2009, Dr. Peter Van Houten, CEO at Sierra Family Medical Clinic (SFMC), received a “Rural Champion Award” by the California State Rural Health Association (CSRHA). Of the 5 recipients, Dr. Van Houten was the only physician to receive the award. Dr. Van Houten and SFMC staff have gained recognition primarily for the pioneering work of integrating mental health services into the primary healthcare setting.
- Phase 1 – learned how to do what they were doing better; Phase II – examined own experiences and figured out how to package it in a way to reach more people. Did more advocacy and mentoring regionally and statewide. Developed DVD on the warm handoff, which is now up on YouTube.

6. Council of Community Clinics (CCC)

a) Consortium History and Description

Founded in 1977, the Council of Community Clinics (CCC) provides centralized support services to 16-member community clinics operating nearly 100 sites in San Diego, Imperial, and Riverside Counties. The mission of the CCC is to represent and support community clinics and health centers in their efforts to provide access to quality health care and related services for the diverse communities they serve with an emphasis on low-income and uninsured populations. The County of San Diego does not operate a public hospital or public clinics, therefore the private, nonprofit community clinics and health centers are the safety net for primary care services for San Diego's low-income and uninsured.

In 2007, CCC received funding for **two** separate integrated behavioral health projects – the Integrated Behavioral Health Project (IBHP), funded by The California Endowment, and the Mental Health and Primary Care Integration Project, funded by the Mental Health Services Act (MHSA) and the County of San Diego. There was significant synergy between these two projects that allowed the CCC to strengthen the capacity across member clinics in the delivery of integrated behavioral health care. Prior to IBHP and MHSA project funding, behavioral health services varied among the 16 CCC member clinics from highly developed and integrated systems of care, to co-located services onsite, to referrals to external community providers. Engaging in the MHSA Integration Project and partnership with the County allowed the CCC to greatly expand access to needed mental health services for the safety net population. IBHP provided resources, technical assistance and knowledge about integrated models of care that was leveraged to the nine clinics participating in the MHSA Integration Project, as well as other CCC member clinics.

b) Motivation for Integration

CCC, their member clinics, and the County of San Diego have different interests and motivations for investing in and supporting integrated behavioral health efforts, and many of these factors have evolved over time in response to changes in the financial and service delivery environment of the county.

Motivation for the Consortium

Initial interest in integrated care stemmed from a commitment to enhancing care quality and responding to the needs of the communities served. With the advent of MHSA, the CCC was able to formalize and encourage the involvement of member clinics in the Mental Health and Primary Care Integration Project to expand access to mental health services through integrated care. Proactive engagement in this collaboration with County Mental Health was motivated by increased demand for mental health services in the community clinic setting.

Part of the more recent motivation for integration at the Consortium level is the economic crisis faced by the county mental health system that reduced availability to services for patients and a desire for greater cross-system collaboration to meet that need. With the recent budget crisis, the County Mental Health system needed to limit mental health service access to the most severe (SPMI) individuals served within the system. With limited funds to serve a mental health population, the county is shifting costs

and trying to work with CCC. As a result, CCC is in the position to work in partnership with county mental health to better leverage resources to manage the stable SMI population through the community clinic system.

CCC acknowledges they would not have gotten into IBH on their own without the MHSA contract. They might have “dabbled” with integrated behavioral health, but without the support of MHSA funding they would not have dedicated staff which was essential to successful implementation. Without participation in MHSA contract, CCC would not have been engaged in IBHP. Now because of the significant learning through the course of project implementation, partnership and collaboration with the county and visibility as a consortium leader, integrated behavioral health is part of the strategic agenda at CCC and a priority area for sustainability.

Motivation for Clinic Members

As a clinic consortium, the CCC sees a great deal of variation in factors motivating clinics to engage in integrated behavioral health. Motivation ranges from having a PCP champion interested in implementing an evidence-based intervention (such as IMPACT), to clinics where all medical providers are motivated and involved, to clinics where the CEO sees an opportunity to secure additional resources such as MHSA funding. CCC feels clinics should be motivated to get the technical assistance to integrate behavioral health services because, in reality, there is a high likelihood that their patient population includes people with mental health issues. In time, there will not really be a choice about whether or not to provide behavioral health services because the demand will be there and clinics will be expected to adapt and respond to community need. PCPs and clinic administrators are motivated once they sit down and hear about integrated behavioral health and how these services can impact the clinic financially in terms of reducing no-shows and increasing provider productivity. Improving overall care quality, treatment compliance and patient outcomes are also motivating factors for clinic providers and leadership.

Motivation for County Partners

County-level buy-in for integrated behavioral health increased because of the recognition that the model is financially viable. There are financial challenges inherent in maintaining a separate mental health service system, including costs associated with hiring licensed bilingual providers, lower productivity, and billable time due to the 50 minute therapy session. County Behavioral Health Services is motivated to partner with CCC because of diminishing resources and unmet need. Although not yet implemented, the County plan is to transfer stable clients to FQHCs so that SMI patients could receive care in the community clinic setting, freeing up resources for mental health services for clients in crisis and in need of specialty services. At the same time, motivated by the knowledge that the SMI population is dying 25 years earlier than the general population, the County wants to enhance access to needed primary care services and be part of the referral system for individuals with serious mental illness who are not accessing needed primary care services.

c) Approach to Integrated Behavioral Healthcare

CCC IBH Model Features

MH/SA Services Provided	Varies by clinic. Two basic models: 1) IMPACT model – an evidence-based model for depression with a depression care manager collaborating with the PCP for medication management; 2) Specialty pool with traditional model of mental health care with therapy and medication management by a psychiatrist
Name of BH Staff	IMPACT Project = Depression Care Managers (DCM) Other Clinics=Behavioral Health Consultants
Patients Seen/Day	IMPACT Project: 5-8/day; 30 minute sessions but length is at discretion of DCM. Their rate is the same whether 30 or 50 minute session; have caseload contact targets .5 FTE of DCM see 96 unduplicated patient caseload/year. On average, IMPACT get 5 visits/year up to 16 in a year. Specialty Pool Program Productivity targets are set by the individual clinic not the consortium
Population Served	IMPACT Project: Patients with Depression Specialty Pool Population: 19% diagnosed with schizophrenia or bi-polar disorder
Productivity Incentives	Not applicable

Behavioral Health Patient Characteristics. The population currently served is low income, ethnically diverse, and high need community clinic patients. In 2007, the clinics involved in the Mental Health and Primary Care Integration Project (MHPCIP) served 1,265 uninsured patients (MHSA funded): 58 youth, 1096 adults, 111 older adults (65+). The demographic breakdown of clients served was: 47% Hispanic, 38% white, 5% black, 3% Asian, and 2% Native American. More than two thirds (67%) of the patients receiving behavioral health services through the program had not previously been served in the County system of care. While stigma around accessing mental health treatment is a primary reason, additional factors affect patient access to needed services including, how to access treatment within the County system, and a lack of awareness that a mental health condition is the underlying issue in need of treatment. Many patients receive mental health services at the community health clinic because they think they need treatment for a medical condition, which turns out to have a psychological component that can be addressed through behavioral health interventions.

Behavioral Health Services Provided. The CCC currently uses two treatment models of behavioral health care within a primary care environment. One model is a specialty pool where a traditional model of mental health care is delivered to patients by a BH clinician with medication management services provided by a psychiatrist. The other model is the IMPACT model, an evidenced-based practice for treating depression with a Depression Care Manager (DCM) collaborating with the patient’s PCP (who provides the medication management).

Clinics across the CCC vary considerably in their capacity, experience and sophistication of their integrated behavioral health programs. More advanced clinic sites have providers with dual-certification in psychiatry and family medicine, and the capacity to serve clients with serious mental illness and complex psychotropic medication and primary care needs. Other clinic sites are easing into integrated behavioral health services by contracting with mental health providers and psychiatrist time on a limited basis.

Screening Procedures. Within the CCC, the use of screening instruments and the administration protocols vary by member clinics. For clinics involved in the IMPACT project, patients are screened at every visit using the PHQ-9. CCC collects and analyzes PHQ-9 data collected by the IMPACT project sites to share with the County.

For other clinics in the consortium, use of screening tools is at the discretion of the clinic, medical director or PCP based on the perceived clinical utility. At many clinics, motivation for universal screening is limited because of a lack of infrastructure to address the range of needs identified. Clinic specific motivation to implement screening tools is usually connected to project or grant requirements. Most clinics will implement widespread screening for specific conditions that have an evidence-based treatment protocol and can be addressed successfully in the primary care setting (e.g., screening diabetes patients for depression). Some PCPs will administer the PHQ-2 based on patient symptoms, but there are no standardized screening protocols across CCC member clinics.

Activities of CCC that Promote Integrated Behavioral Health. CCC has adopted an approach to advancing the field of integrated behavioral health modeled after the IBHP strategy. CCC has not endorsed any particular model of integration, but has invested resources in training and technical assistance activities that build the capacity of community clinics. CCC also participates in local, regional and statewide conferences and collaborative to build awareness and visibility of integrated behavioral health.

Applying IBHP Learning to Clinic Membership. CCC entered into a contract with the County Behavioral Health Services in December 2006 to implement the Mental Health and Primary Care Services Integration Project funded through MHSA. CCC spent Phase I of IBHP learning about the range of integration approaches and strategies. CCC's implementation approach was to expose member clinics to a variety of IBH philosophies and allow clinics to choose the model that worked best given clinic capacity and community need. Common to all of the model approaches is the PCP extension model where BH providers serve the needs of both the patient and the PCP within the clinic setting.

Project leadership at CCC had limited knowledge of the IMPACT model prior to the MHSA funded Integration Project. Participation in IBHP and the Learning Community exposed CCC to invaluable resources and content experts that they were able to bring to consortium members. Prior to IBHP, CCC was unaware of the work of the five IBH experts they ultimately brought in as part of their Phase II technical assistance project. CCC attributes much of their implementation success of their MHSA Integration Project to participation in IBHP and the timing and overlap of the two initiatives.

Technical Assistance and Training Activities. To enhance the capacity of the Depression Care Managers in the clinics implementing the IMPACT model to address behavioral aspects of physical illnesses, CCC provided training on a range of topics including: motivational interviewing, psychotropic medications, diabetes and depression, chronic pain management, maternal depression, CBD/heart disease.

CCC organized and facilitated a half-day IBH workshop to introduce clinic leadership to integration concepts with the expectation that clinic leadership would arrange for further training from one of the experts in attendance. 13 clinic organizations attended and heard presentations from four experts –

Kathy Reynolds, Patricia Robinson, Larry Mauksch, and Bill Rosenfeld, and 9 clinics signed on for additional consultation on integrated behavioral health with one of the experts.

Challenges Implementing Integrated Behavioral Health in Community Clinic Setting. The CCC identified several challenges associated with implementing IBH in the community clinic, including partnership, workforce, data sharing and financial issues.

Partnership Issues:

- Collaboration with County Behavioral Health Services takes time and requires the development of a common language to understand the interests of each system
- Complicating the development of a common language is inconsistencies in terminology. The mental health field commonly uses the term “behavioral health” to depict mental health and substance use services, and in many primary care settings, substance abuse treatment is not included or available

Data Tracking and Information Sharing:

- Several clinics continue to maintain separate records between primary care and mental health which does not promote collaboration
- Even in clinics where MH services are co-located and under the same roof as PC, MH may chart separately and there is limited care coordination
- Competing priorities for implementing i2i modules on topics other than mental health (women’s health and diabetes) have postponed progress on integrating mental health into the database for tracking
- All the clinics in the consortium have different productivity standards, which affects case conferencing and information sharing. Clinic administrators have varying levels of support for carving out time for non-billable case consultation. CCC has addressed this issue to some degree by developing a case consultation rate, but not all clinics participate in this service.

Workforce Issues:

- Training existing practitioners to work effectively in PC settings
- MFT not being reimbursable provider for Medi-Cal. CCC can hire MFT clinicians under MHSA grant at IMPACT project clinics, but not at FQHCs.
- Staff turnover is an ongoing challenge. CCC member clinic have had 140% turnover in 2.5 years in the IMPACT DCM position. Shifting MH providers to CHC setting as more patients transfer to CHC for care, creates challenge of adapting to PC environment (faster pace, higher productivity expectations, more interruptions, coordination and case conferencing expectations with medical provider staff)

Financial Issues:

- Same day billing for mental health and primary care visits
- Financing Barrier – low FQHC reimbursement rate for the Psychiatric Assessment, as the reimbursement rate is the same whether it's conducted by a BHC or a psychiatrist. Financially, it makes more sense for clinics to have BHCs conduct the assessment; however, this can affect client care because psychiatrists prefer doing the assessment themselves.

Core Components of Integrated Services Model. CCC identified the following core components of a successful integrated services model:

At a minimum, integrated services need to have formalized communication opportunities through case conferencing and integrated records. Also essential to IBH is access to consulting psychiatry to support the PCP in managing patients with complex MH conditions.

d) Goal and Accomplishments on Innovative Project

For the IBHP Phase II Innovative Project, the CCC focused on training medical and behavioral providers, increasing opportunities for case consultation, and providing technical assistance to clinic administrators. The following section highlights the goals and accomplishments of their Innovative Project implemented during October 2008 and September 2009.

Goal 1: Increase cross-training between primary health and behavioral health staff

- Nearly 50 clinic staff members from 13 clinic organizations attended a half-day IBH workshop lead by four national experts (Kathy Reynolds, Patricia Robinson, Larry Mausch, and Bill Rosenfeld) on integrated behavioral health. The goal of the workshop was to introduce clinic leadership to integration experts with the expectation that clinics would then arrange for technical assistance sessions with one of the experts. Overall, training participants rated the training with high marks.
- Seven trainings, attended by over 70 PCPs, were conducted for PCPs on the use and dosing of psychotropic medications. To enhance attendance, trainings were held on-site at clinics during regularly scheduled PCP meetings. The CCC collaborated with a County Behavioral Health Department contracted training provider to organize and finance the trainings. The trainings were conducted by David Folsom, MD, a CCC consultant and double board certified family medicine/psychiatrist.

Goal 2: Increase the frequency of and/or time allotted for team care conferencing.

- CCC worked with the County to obtain approval to reimburse clinics participating in the MHSA funded integration programs for staff time to convene multi-disciplinary team care conferencing consisting of PCPs, behavioral health clinicians, and psychiatrists to develop interdisciplinary treatment plans. The negotiated reimbursement rate is \$2.61/minute.

- During the IBHP funded period, clinics billed for multidisciplinary care team conferencing for nearly 80 clients (a total of 134 care team conferencing claims) for an average cost of \$33/patient.
- Clinic reimbursement forms were customized to include billing for the multidisciplinary care team conferencing.
- CCC worked to increase the use of standardized protocols to document the care team conferencing. These protocols were developed with input from representatives of clinic organizations and included four clinicians, 2 PCPs, and a psychiatrist. The resulting protocol requires that one member of the treatment team (usually the mental health clinician) assume responsibility as chair for the treatment team meetings. Notes of case discussions and decisions are to be entered directly in the patient's chart. In clinics that keep separate primary care and mental health charts, notes are to be entered into each chart.
- More than 40 staff were trained in using the protocol and billing for care team conferencing.

Goal 3: Customize i2i Tracks to integrate primary care and behavioral health records

- During the funding period, 2 of the 9 participating clinics implemented i2i
- The module integrating primary care and behavioral health records was less of a priority for the clinics rolling out i2i than modules on diabetes and women's health issues
- Immunization became a high priority for i2i because of the interface with the San Diego Immunization Registry

Goal 4: Facilitate provider access to experts within the field of integration

- Five integration experts (Kathy Reynolds, Patricia Robinson, Larry Mauksch, Bill Rosenfeld, and Dennis Freeman) were contracted to provide technical consultation to 9 clinics, which were given the opportunity to select the expert that best fit their needs and interests.
- As a result of these consultations, 5 clinics reported significant changes:
 - Clinic 1 – Moved a mental health clinician into primary care to work as both a Depression Care Manager and a Behavioral Health Consultant.
 - Clinic 2 – Closed their "traditional" mental health department, which was separate from the rest of the clinic and are moving all mental health providers into the primary care clinic.
 - Clinic 3 – Hired a social worker as a BHC in primary care
 - Clinic 4 – Placed an LCSW in pediatric primary care
 - Clinic 5 – Moving from a separate mental health department to an integrated model

Goal 5: Enhance the capacity of the behavioral health program to address behavioral aspects of physical illness

- Depression care managers received training on the behavioral aspects of various medical conditions to better support the PCP in treating patients. Topics included: diabetes, chronic

pain, hypertension and cardio-vascular disease, psychotropic medications, maternal depression, and motivational interviewing.

Goal 6: Provide technical assistance to clinic consortia throughout California regarding the development and implementation of an integrated MHSa funded program across multiple sites

- CCC staff presented at numerous conferences and symposia across CA, including an annual symposium organized by the Community Clinic Association of Los Angeles County, the Coalition of Orange County Community Clinics, and CCC.
- CCC staff provided technical assistance to Clinicas de Salud Del Pueblo, a Federally Qualified Health Center organization with 10 clinics located in Imperial and Riverside Counties on topics including MHSa funding streams and an introduction to the IMPACT model, joint meetings between FQHC and County MH to enhance collaboration as well as various operational issues related to integrated care.

Other Accomplishments:

- Leveraged the infrastructure built through the IBHP to secure SAMHSA grant
- CCC board has included integrated behavioral health in the 3 year strategic plan.

V. Core Model Components for Integrated Care

The five vanguard clinics funded through IBHP show a great deal of variation in how integrated services are implemented. The table in **Appendix A** presents a comparison of the five clinics on elements of their approach to integrated behavioral health, such as services provided, screening instruments used, strategies for case management, and others.

Despite the cross-clinic variation in integration approach, the clinics identified the following as important or core components of integrated care:

Core Components of Integrated Behavioral Health

Clinical Components
<ul style="list-style-type: none"> • Collaborative team approach with a shared philosophy of care for the patient • Co-location—providers sharing the same physical space/close proximity • Universal Screening to identify behavioral health needs of the population • Routine communication, consultation, and coordination across medical and behavioral health providers • Access to psychiatric consultation for PCPs and other medical providers
Administrative
<ul style="list-style-type: none"> • Structures to support information sharing through medical records and case consultation • Buy in from medical providers, behavioral health providers, and administration/management • IT infrastructure (e.g., registries) to track behavioral health data and clinical outcomes • Educational materials and strategies to augment behavioral health staff role
Financial
<ul style="list-style-type: none"> • Financial mechanisms that support the core clinical components, such as the warm handoff, case management, crisis intervention, and case consultation

VI. Integration Challenges and Lessons Learned Across the IBHP Vanguard Sites

Over the course of IBHP Phase 1 and 2, the IBHP grantees identified a number of on-going challenges and lessons learned that can inform the field of integrated behavioral health, including community health clinics, philanthropic organizations, researchers, policymakers and provider association interested

in developing or investing in field-generated models of integrated behavioral health. The collective experiences of the IBHP vanguard clinics — both successes and challenges — generated significant lessons in the areas of program implementation start-up, clinical integration, administration, financing and sustainability. The challenges and lessons learned are summarized in the following tables.

Summary of Challenges and Lessons Learned from the IBHP Vanguard Sites

Program Implementation Start-Up

Lessons Learned:

- At start up, numerous areas need to be addressed for successful implementation, including: medical provider training, administrative financial support, BHC acclimation to primary care setting, developing and strengthening community partnerships (county mental health and social service agencies), and culture change for patients (interacting with a BHC at a primary care clinic).
- The value of and buy-in for integrated care needs to be modeled and enforced from administrators and clinical leaders (e.g., medical directors)
- To facilitate start-up, it helps to use a strategy of mandatory referrals for patients on sleep medication, Benzodiazapines, and pain medications. This helps reinforce the idea among PCPs that there is a behavioral health program available and the referral becomes a normative practice in the clinic. It also helps fill up the time slots of the BHC when the program is new and referrals may be slow.
- Administrators need a realistic understanding of the timeline for a new behavioral health program because it is different from opening a medical clinic. It requires a long term investment and it may take two to three years to break even. It can often take that long for the BHCs to become fully comfortable communicating with the medical providers about medications and care plans for medical conditions.
- Planning an integrated behavioral health program requires understanding the case mix and complexity of the patient population, as well as the availability of specialty care in the public mental health system when patients with high MH acuity present in the clinic.
- It is important to maintain a running record of implementation decisions and clear documentation of provider roles and methods for communication. This facilitates “manualizing” the program and training new providers hired after the program is operating.

Clinical

Challenges:

- For patients, it takes time to explain the role of the BHC, what happens during a visit, how the BHC works with the medical provider, and to address issues related to stigma. The need for repetitive education with the patient can affect physician buy-in because it takes patience and commitment to push through the resistance to change.
- Staff turnover of medical providers can threaten successful integration. The model is vulnerable because providers need to be trained anew and the rapport has to be re-established, which can send a ripple effect through the program.
- Lack of role clarification between primary care and behavioral health providers, and no standardized language to articulate the concepts of integrated behavioral health can affect provider buy-in and service delivery efficiencies.
- Lack of medical provider knowledge in psychopharmacology is an ongoing challenge of integrated behavioral health.
- Providers on the ground need greater awareness of the impact of mental illness on physical health. PCPs need more information and training on psychotropic medications and there needs to be better cooperation and buy-in from psychiatry.

- PCPs need more education related to pain management protocol implementation.
- Clinic size influences the effectiveness of the warm handoff. In a smaller clinic with less volume, there are more opportunities for a successful warm hand-off.
- Primary care tends to focus on chronic disease management rather than prevention. Prevention is an integral part of the IBH philosophy.
- Time and opportunities for training, education and technical assistance targeted to IBH is limited.

Lessons Learned:

- The transition from the MH system to the primary care setting takes time (6-12 months to fully acclimate) and is not for everybody. Needed adjustments include time management, dealing with interruptions, accelerating the time it takes to make a diagnosis and understanding billing for different insurance providers.
- With change, there will always be staff who resist. Establish a plan for dealing with resistance. It helps to keep patients and their interests front and center.
- Research shows between 70-80% of organic diseases have a psychological cause or association. There is a need for training tools that focus on the interconnectedness of psychological and medical issues.
- Systematic use of screening instruments is important because it elevates awareness of behavioral health issues for medical providers and identifies needed treatment intervention.
- IBH training modules that are essential for general practice physicians and family providers include: IBH 101, psychopharmacology, mental health diagnoses, pain management, and suicide prevention.
- Medical provider training must come from another medical provider to maximize effectiveness and receptivity.
- Psychiatry needs to play more of a leadership role in the integrated model rather than serving just as a means to an end (for dispensing and monitoring medication).
- Providing in depth health education to patients and families about illnesses and psychiatric conditions helps with medication compliance and reinforces messages from the medical provider.
- If a clinic integrates health and mental health services, it is philosophically consistent also to integrate social services because of the connection to overall health and wellness.
- Initiating a universal policy that pain management patients participate in behavioral health services sets patient expectations up front that helps alleviate any negative or “punitive” association with behavioral health services for patients with chronic pain. It is important to reframe pain management program requirements as improving the quality of care and providing additional services and resources for patients to better manage chronic pain.
- In a clinic system, different clinic sites serve different populations with varying levels of behavioral health complexity. Therefore, the most effective integrated behavioral health approach and staffing composition may not be uniform across the clinic system.

Administrative/Operations

Challenges:

- What motivates clinic leadership (CEO and CFO) and providers is different, and often there are gaps in knowledge about IBH between providers and administrators.
- Buy-in and messaging should be tailored for different groups: Integrated behavioral health is a natural fit if there is a holistic mindset towards care. For PCPs or CEOs, the language and buy in may need to be framed as standards of care linked to quality assurance. It is more than the right thing to do because practicing integrated care is good medicine given the interconnectedness of physical and mental health.
- Progression along the integration continuum is not a linear process and is vulnerable to changes (e.g., budget, staffing, etc.) that result in less integration (i.e., slippage back to parallel or separate systems of primary care and behavioral health services).
- There is often resistance by administrators to sacrifice provider productivity time to support case conferencing and consultation.

Lessons Learned:

- Behavioral health providers need to be visible and accessible to medical staff. Information on behavioral health services and a collaborative care model need to be shared at orientation with new medical staff.
- It is important to support cross educational opportunities between behavioral health and primary care providers. All providers like to demonstrate expertise, so create opportunities for each side to talk about their field and educate the other discipline.
- Keep valuable data and metrics accessible to both sides. Providers and administrators do not have time to look for data to demonstrate effectiveness. Data from screening tools need to go somewhere where they can be used clinically.
- Communication is essential for developing a common language between psychology and medicine.
- It is important to obtain support from administrators regarding the value of case conferencing and case consultation between BHCs and medical staff. PCPs need to make the case that the apparent trade off of productivity for case conferencing time in the long run leads to increased productivity, better client outcomes, and increase medical provider satisfaction.
- Consortia need to support their members in moving toward integration and to address the growing need for behavioral health services among community clinic clients.

Financing & Sustainability

Challenges:

- There is a lack of reimbursement for critical components of IBH: same-day visit (including crisis intervention), the warm hand-off, case management services and consultation between medical and behavioral providers.
- Integrated behavioral health programs thrive on all the pieces working together, which includes immediate access to the BHC. Gaps in the schedule can lead to regression of the model.
- Fund development and pursuit of collaborative grants requires that CEO and grant writers work together on identifying potential opportunities and joint decision-making on which grants to pursue
- If integration activities are funded as pilots with short-term start-up funding, rather than growing out of a recognized need of the client served by a clinic, the clinic is more at risk of not sustaining the integrated care when the funding goes away.
- Strosahl promoted the model as a profitable endeavor, but this is not necessarily the case when the mental health and addiction acuity of the population increases.

Lessons Learned:

- It can take 2-3 years for an IBH program to become cost neutral and financially sustainable.
- Examine the clinic's Medicaid PPS rate. Consider factoring integrated behavioral health services to apply for an increase.
- Administrative costs are fixed. The real cost is with the BHC salary. If the salary does not exceed more than 80% of the revenue, the behavioral health program can break even.
- Sustainability at the consortia level requires funding for dedicated staff. Funding these positions through grant funds could be a problem if these resources disappear.
- Maintaining the IBH culture is dependent on proximity, communication, solid availability and limited staff turnover. BH "floats" can sustain the process. "It's easy to get rusty on sustaining integration when operational and clinical flow takes over."
- MHSA can open up opportunities for regular communication between MH and PC, which can lead to discussions about where the client should have a medical home and moving stable clients from MH to the medical clinics. These discussions can lead to important new strategic partnerships with County Mental Health.
- Successful strategies in building a partnership with County Mental Health include, taking stable patients to free up the capacity of county mental health and participating on each others' boards to facilitate cross-system communication and knowledge.
- Community clinics acting as the medical home for SPMI served by County Mental Health is a natural collaboration point with the mental health system managing the mental health condition, and the community

clinic managing the physical side effects of psychotropic medications, as well as monitoring issues related to metabolic syndrome.

VII. Conclusion

The case studies and cross program learnings presented in this report provide field-generated evidence of the role community clinics play and the important messages they use in promoting access to and delivery of behavioral health services for the safety-net population through integrated behavioral health care.

Community Health Centers play a vital role in delivering behavioral health services to the safety net populations. Integrated behavioral health programs offer a shared service delivery and a team approach to care, which promotes collective accountability for patient care. Community Health Clinics offer individuals across the continuum of MH/SU complexity a range of behavioral health services that may otherwise not be available in the community. The vanguard clinics understand that patients with more severe mental illness, who are not yet stable and require more frequent visits and peer supports, will access this level of care in specialty mental health settings. However, Community Health Clinics do treat patients with a spectrum of behavioral health need and provide access to psychiatry services and medication management, individual and group therapy, substance abuse treatment services, and care coordination, often without waiting lists for services.

The vanguard clinics offered practical advice on making the case for clinics to implement integrated care. In making the case for integrated behavioral health, it is important to understand that different stakeholder audiences have different priorities regarding the outcomes and evidence they find compelling. Building a successful argument for integration requires a tailored message and communication strategy based on the values and priorities of the audience. To make the case to community health clinic administrators and leadership, the vanguard clinics identified several themes to address:

- Enhanced quality improvement and assurance
- Increased provider productivity
- Neutral financial impact
- Reduced patient complaints
- Improved provider satisfaction and retention
- Increased competitiveness and success in provider recruitment and
- Promotion of clinic mission (responsiveness to community needs).

To generate buy-in and make the case for integrated care among medical providers, the vanguard clinics highlighted the following outcomes:

- Positive clinical outcomes (including chronic conditions such as diabetes)
- Shifting the balance of care from disease management to prevention
- Reduced burden from difficult to treat patients

- Improved patient and provider satisfaction
- Fewer staff and patient complaints
- Improved self-care management
- Increased access to needed mental health treatment among patients not eligible for county mental health
- Improved medication compliance and
- Reduction in medication use by pain management patients

Appendix A: IBHP Vanguard Clinic Model Description Tables

Integrated Behavioral Health Program Characteristics by Clinic

IBHP Vanguard Clinics: Approach to Integrated Behavioral Health

	Family Health Centers of San Diego	Golden Valley Health Centers	Mendocino Community Health Clinic	Open Door Community Health Centers	Sierra Family
Motivation for Integration	<ul style="list-style-type: none"> Desire to be responsive to the needs of community Long history of providing BH services since 1980s Freestanding MH clinic since 1990s Co-located BH in Primary Care clinic in 2003 when joined Health Disparities Collaborative All new clinics open since 1998 have dedicated space for BH services 	<ul style="list-style-type: none"> Introduced to IBH through Kirk Strosahl Implemented IBH to be more responsive to needs of patients in the community BH is not a “program” but part of the array of services BH services are intended to promote wellness and motivate patients to take a preventative approach to health 	<ul style="list-style-type: none"> Open Door served as an early mentor and introduced the Strosahl model Utility of IBH stood out due to the MH and addiction severity of the patient population PCPs welcomed the expertise and assistance of MH providers given patient needs Medical Director is a Certified Addictions Specialist and serves as a champion to IBH approach to care 	<ul style="list-style-type: none"> Open Door was one of the 1st clinics in the nation to implement the Strosahl Model Executive Director thought model would increase clinic revenue through greater PCP productivity PCPs were motivated by improvements in care quality and patient outcomes 	<ul style="list-style-type: none"> Desire to improve the quality of care and be responsive to the needs of patients in the community High demand for BH services at the clinic Conducted universal screen of health/MH conditions at clinic and found much higher rates of depression, GAD, bipolar disorder, and alcohol use than diabetes Clinic spent more time/resources addressing diabetes than all other conditions combined
Title of Behavioral Health Provider	Peer Consultant	Behavioral Health Clinician(BHC)	Primary Care Consultant (PCC)	Behavioral Health Consultant (BHC)	Behavioral Health Consultant (BHC)
Patients Seen/Day	6-10 billable	14-15 scheduled	12 schedule based	9 patients/day to	8-10/day; no show rate of

	Family Health Centers of San Diego	Golden Valley Health Centers	Mendocino Community Health Clinic	Open Door Community Health Centers	Sierra Family
	patients/day, plus uninsured patients and warm hand-offs	based on 40% no-show rate, with 2-4 warm hand-offs	on 25% no-show rate 8 patients/day to achieve cost neutrality	achieve cost neutrality	20%; 9 patients/day to achieve cost neutrality
Diagnoses of Population Served	80-85% meet SMI criteria (Major Depression, Anxiety, PTSD)	66% meet SMI criteria; 2% have Primary Substance Abuse Diagnosis; 38% have other BH issues	58% meet SMI criteria; 11% have Primary Substance Abuse Diagnosis; 31% have other BH issues	60% meet SMI criteria; 14% have Primary Substance Abuse Diagnosis; 26% have other BH issues	75% meet SMI criteria; 4% have Primary Substance Abuse Diagnosis; 21% have other BH issues
MH/SA Services Provided	Mental health assessments; crisis intervention; individual, group and family therapy; adult and child psychiatry; clinic, home and school-based services; certified Domestic Violence Prevention program; linkage to community resources; referrals to SA treatment; assistance with self-care management; provision of psycho-	On-site Psychiatrist; Individual therapy; Groups – compulsive disorders (nicotine, alcohol, other drugs, gambling, binge eating, etc.), pain management, health promotion campaigns (depression, obesity, substance abuse)	Counseling and psychotherapy, addictions treatment (including a Suboxone program), chronic disease management and psychiatry services.	On-site Psychiatrist; Individual therapy; EMDR Groups – pain management; wellness; diabetes management; weight loss; anger management; anxiety; PTSD; Buprenorphine Diagnosis specific peer support groups; mobile medical Suboxone treatment for	Individual counseling; Lifestyle management (i.e., weight loss, smoking cessation, chronic pain management, depression management, and diabetes compliance); Couples counseling; family communication; parenting skills; ADHD treatment for children and adults; Relaxation/yoga/meditation; AoD services using 12 step model; Tele-psychiatry, on-site psychiatry services from county mental health one afternoon/week

	Family Health Centers of San Diego	Golden Valley Health Centers	Mendocino Community Health Clinic	Open Door Community Health Centers	Sierra Family
	educational materials; co-facilitation of pain management groups with PCP			homeless	
Productivity Incentives	\$5 Incentive cards to clinicians for seeing 8+ patients daily	Productivity incentives are based on a monthly average; can be achieved with 10 visits a day (reimbursed or non-reimbursed)	Providers can achieve incentives after the 7 th visit but incentives are being evaluated to include quality and outcome measures	Productivity incentives are based on a monthly average; can be achieved with 6 visits a day	Productivity incentives are not used
Screening Procedures	<p>All new PC patients are screened with PHQ-9 as part of registration packet</p> <p>CAGE used to screen for SA as needed or by request of PCP</p> <p>Women receiving pre-natal services are screened for depression using Edinburgh Depression Scale</p>	<p>Adult Health History form (all new patients and every 5 yrs.) includes universal screen for nicotine/ alcohol use, depression, anxiety and domestic violence</p> <p>PHQ-9 is used to screen geriatric, diabetic and post-partum patients for depression</p>	<p>Universal biopsychosocial screening instrument which incorporates PHQ-2, domestic violence, substance use, and other health behaviors questions annually</p> <p>Screening tools are used at the discretion of the BHC based on clinical judgment and patient need.</p>	<p>PHQ-9 for Diabetic patient only</p> <p>EMR (not yet implemented) will include 15 different BH screening tools and a protocol will be developed to assist medical providers in knowing who and when to screen.</p>	<p>All adults medical and dental patients are screened for co-occurring disorders using Modified Mini Screen</p> <p>PCP uses PHQ-9 to screen for depression and MDQ for patients with anxiety to rule out Bipolar disorder prior to prescribing psychotropic medication</p>

	Family Health Centers of San Diego	Golden Valley Health Centers	Mendocino Community Health Clinic	Open Door Community Health Centers	Sierra Family
		<p>Geriatric patients screened with MMSE</p> <p>Children 18-24 months are screened for autism</p> <p>Children age 4-17 are assessed with Pediatric Symptom Checklist</p>	<p>Screening/tracking clinical outcomes is essential to evaluate effectiveness of BH interventions</p> <p>Example Tools: PHQ-9; CAGE; OASIS; Subjective Unit of Distress (SUD); Pain Self-Efficacy Questionnaire (PSEQ); Session Rating Scale, Outcome Rating Scale to determine effectiveness of therapy</p>		
“Warm Hand-Off” between PC and BH Providers	Warm Handoff occurs in the exam room, and an appointment is scheduled for follow-up. PCP introduces that behavioral health provider as a “peer consultant.” BH provider takes the patient to a separate office to	PCP establishes to point of the visit during the warm hand-off. BHCs are notified by cell phone. Most patients do not wait more than 15 minutes for BHC	Warm Hand-Offs happen infrequently and typically when BH staff has a no-show. Also limited because of inability to bill for same day services. Will work immediately w/PCPs on prescription intervention	Warm Handoff occurs when patient has acute symptoms and needs stabilization. With increasing demands on the BHCs, there have been far fewer opportunities for warm hand-offs from PCPs with the exception of crisis	<p>PCP slips a referral form under the door of the BHC with vital information on patient: patient location, insurance status, specific issue to be addressed and level of urgency</p> <p>PCP introduces BHC as part of the team and patient witnesses the collaboration between the providers</p>

	Family Health Centers of San Diego	Golden Valley Health Centers	Mendocino Community Health Clinic	Open Door Community Health Centers	Sierra Family
	free up space in the medical exam room.			situations.	
Case Management	BH staff provide CM services. Rely on a community resource binder of that has been developed over time. Clinic tries not to hire BH staff that are not willing to do some level of Case Management	BHC performs CM duties. Rely on CBO partners for referrals. BHCs will make 3-way calls with the patient at the clinic to access food stamps, housing, SSI income benefits. BHCs build CM activities into their schedule, but this is not billable time. There is no system in place for follow up on referrals made or to track outcomes of referrals.	Rely on grants to fund case management services; when grant funding ends, this function is politically vulnerable in the clinic setting. To build the case for case management services, MCHC is interested in tracking the following measures: productivity of medical providers before and after implementation of case management services; patient satisfaction; no-show rates; referrals to other social service systems; and provider satisfaction.	Pilot program that pairs a CM with a psychiatric nurse practitioner to demonstrate the effectiveness of this position at the clinic. CM will provide benefits advocacy to connect uninsured clients to MediCal, CMSP, or Medicare Part D, to impact clinic financially. Data measures will include: show rates, cycle times, access to PCPs after BH, provider satisfaction, patient satisfaction, and improvements in mental health outcomes	Contracts for CM services 1 afternoon a week through County MH Resource Connection grant BHC performs CM duties during the other days.

	Family Health Centers of San Diego	Golden Valley Health Centers	Mendocino Community Health Clinic	Open Door Community Health Centers	Sierra Family

	Family Health Centers of San Diego	Golden Valley Health Centers	Mendocino Community Health Clinic	Open Door Community Health Centers	Sierra Family
Information Sharing through Medical Records	Paper charts currently used; PCP reviews PHQ-9 scores and case notes under the MH tab of the shared chart; EMR implementation is underway.	EMR is accessible to PCPs and BHCs for PHQ-9 scores and Shared Problem List BHCs track progress on therapeutic goals in shared case notes There is no Integrated Care Plan	Integrated charts for medical providers and BH staff. Clinic is currently implementing EMR	Open Door is currently implementing EMR with a BH module. Expectations are high that EMR will enhance care coordination across provider groups and enable behavioral health outcome tracking.	Integrated medical records; paper charts
Communication & Coordination across Providers	Weekly meetings between PCP/BH staff PCP often involves BH staff in consultations with Psychiatrist BH staff present monthly MH educational seminars to all medical staff Disseminate a weekly newsletter to 700 employees across the	No formal case conferencing with PC and BH providers for 2 reasons: 1) not financially feasible to carve out time of highest paid providers to discuss a few cases out of thousands; and 2) patient care meetings without the patient present are not helpful or supported by administration.	Integrated case conferencing is considered essential to IBH model	Formal case conferencing between PCP, BHC and psychiatrist on a case by case basis	Staff size is small (1 PCP and 1 BHC) so maintaining communication about shared cases happens routinely

	Family Health Centers of San Diego	Golden Valley Health Centers	Mendocino Community Health Clinic	Open Door Community Health Centers	Sierra Family
	clinic system called “Weekly Huddle” to share patient case studies and impact of BH services on health outcomes	Communicate through shared case notes, email, EMR, bi-monthly trainings for providers and “micro trainings” of procedural issues to facilitate greater coordination			
Implementation Challenges	<p>Restrictions on Same Day Billing</p> <p>Staff turnover and training new BH providers on how to work in clinic setting</p> <p>Service gaps: SA detox programs; psychiatry services for uninsured patients; limited access to child psychiatry</p> <p>Medical provider resistance</p> <p>Lack of standard</p>	<p>Variation in medical provider buy-in</p> <p>BH screening items added to the Adult Health History Form are collected and then not systematically used by the PCP</p> <p>Integration is not present in the IT system</p> <p>Lack of parity at Leadership level for BH Director in decision-making</p>	<p>Lack of data on outcomes of IBH care in the clinic</p> <p>Need EMR to link providers across discipline and examining impact of integrated care</p> <p>No reimbursement for Case management</p> <p>CM is critical, especially as severity increases</p>	<p>Maintaining the integrated model during times of fiscal crisis</p> <p>Need for ongoing training and standardized manuals to train new staff</p> <p>TA for CEOs and administrators on legal issues that need clarification (e.g., record keeping, HIPAA interpretations, mandatory reporting requirements of MH providers)</p>	<p>Medical provider resistance and maintaining buy-in</p> <p>Being patient at start-up to allow the program to grow before the clinic sees cost neutrality</p>

	Family Health Centers of San Diego	Golden Valley Health Centers	Mendocino Community Health Clinic	Open Door Community Health Centers	Sierra Family
	procedures for IBH Integrated care philosophy is not part of job descriptions, training manual or performance reviews	Inconsistent clinical intervention based on different priorities of PCP, BHC and patient			
Core Components of Integration	<p>Co-Location Collaborative Team Approach</p> <p>Buy-in from medical providers and clinic leadership</p> <p>Routine communication across providers</p> <p>Information sharing through medical records and case conferencing</p> <p>Case Management and Warm Hand-Off are essential components even though not reimbursed</p>	<p>Co-Location and Proximity of provider team</p> <p>Access to Psychiatry for direct services and consultation, support and education of PCP</p> <p>Presence of BH beyond face-to-face time of provider (educational material available in exam rooms and nurse stations)</p> <p>Population Based approach to Prevention that includes BH component in wellness and health</p>	<p>Co-Location and close proximity of PC and BH providers</p> <p>Screening to identify needs and evaluating effectiveness of treatment</p> <p>Cross-system collaboration</p> <p>Integrated case conferencing</p> <p>Data sharing and outcome tracking</p> <p>Case Management Services</p> <p>Electronic Medical Records</p>	<p>Co-Location</p> <p>Treatment philosophy that behavioral health is essential to patient care</p> <p>Buy-in from clinic leadership</p> <p>Universal screening to identify behavioral health conditions</p> <p>Communication and training across providers</p> <p>Financial support for vital functions (technology, case conferencing, same day visits, and case</p>	<p>Co-Location is important but not sufficient –need a fully integrated approach that fosters a mind-body connection by approaching disease management, lifestyle management and pain management from both a medical and psychological lens</p> <p>Medical provider and Administrative buy-in</p> <p>BHC staff with strong skill set to adapt to the PC setting</p>

	Family Health Centers of San Diego	Golden Valley Health Centers	Mendocino Community Health Clinic	Open Door Community Health Centers	Sierra Family
				<p>management)</p> <p>Information sharing through medical records and case conferencing</p> <p>Data tracking to demonstrate clinical outcomes (registries, I2I)</p>	

